The MODERN HOSPITAL

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXIV *June 1925* No. 6

BUDGETARY CONTROL OF HOSPITAL FINANCE*

By R. N. BROUGH, Comptroller, New York Post-Graduate Medical School and Hospital, New York, N. Y.

IT IS assumed that any hospital intending to avail itself of the advantages of budgetary control has already placed its bookkeeping in competent hands and uses a double-entry system. One other essential must be faced, if satisfactory results are to be obtained. Materials for general use must be purchased in reasonable quantities and issued upon requisition to the various departments. In other words they must be handled upon an inventory basis. This is so obviously the proper method of avoiding unduly high prices and unnecessary waste because of lack of control in the use of material, that, as previously indicated, it should be followed irrespective of any budgetary consideration. Materials are often more valuable than money, particularly in the care of the sick. It is a mystery why some people proceed on the theory that cash should be doubly safeguarded while materials are allowed to take care of themselves. But aside from that point, we cannot afford to guess when reporting actual monthly expenses in comparison with the approved appropriation. Each department should be charged with the actual supplies used.

The proper figures can only be secured by installing a common-sense inventory system and pricing the requisitions for supplies used. Materials used exclusively by one department, such as food, coal, and operating room supplies, are an exception to this rule. Such items can be charged directly to the departments concerned. Then at the end of the month an estimate may be made of the value of the inventory on hand. In the case of food the steward will undoubtedly be able to furnish accurate figures. The engineer will have no difficulty in estimating the quantity of coal on hand; and, as a practical matter, the inventory of the supplies on hand in other departments may be disregarded in many hospitals on the theory that all supplies ordered for them are either in use or become an expense of that department as soon as received. A decision can readily be made as to how far this suggestion should be carried into effect, depending upon how much refinement is desired in bookkeeping. For instance, some institutions may desire to carry a linen inventory and to charge the various departments with the linen used. Other smaller hospitals may find this unnecessary, and, as a result, will charge into the monthly accounts all linen purchased.

Accounting for Drugs Perplexing

The most perplexing and annoying problem along this line will undoubtedly be the accounting for drugs used. As a general rule, the local situation should be gone over with the pharmacist. If possible, a wholesale drugroom should be set apart and a record kept of the quantities or articles withdrawn from such stock each day. This will provide a means of keeping a drug inventory account upon the books, as all drugs purchased may be charged to the inventory account and at the end of the month the pharmacy or other departments may be debited with the total value of the quantity withdrawn, as shown by the record mentioned. Likewise the pharmacy should deliver drugs to the various departments of the hospital, such as nursing or laboratory, only upon requisitions which should be priced by one of the clerks in the pharmacy and forwarded daily or weekly to the accounting department, where they may be readily summarized and at the end of the month an entry made charging such departments and crediting the pharmacy.

*This is the second article on budgetary control, prepared for THE MODERN HOSPITAL by Mr. Brough. The first appeared in the May issue, p. 397.

Common sense will indicate the most practical way of doing this. The only principle to be remembered is that the field of guesswork should not be invaded for the purpose of reducing the expense. As reasonable accuracy is the desired result, figures that are correct to the penny are not essential.

Any approved plan for budgetary control involves as one of its fundamentals the preparation of the budget in cooperation with the heads of departments as previously explained. This is primarily for the purpose of securing their active interest in the entire scheme, as no budget can render its fullest benefits unless all those concerned with its operation feel they have a part in securing the desired result, that is, the maximum of service with the minimum expenditure. A little diplomacy will bring about an atmosphere of cooperation. At a monthly conference with departmental heads following the adoption of a budgetary plan, a superintendent said, "In the old days the financial responsibility rested largely upon one pair of shoulders and the weight was heavy. Now we have distributed the load among a dozen or sixteen people, all of whom are helping to bring about a modern and efficient business administration. The more personal interest each one takes along this line, the more we are able to increase our service to the public and the greater the satisfaction in an important work well done." The members of the group mentioned entered into the spirit of the program. It became a matter of pride to have a department operate smoothly and at the same time make a favorable showing in comparison with the budget, from the standpoint of both revenue and expenses.

That is the desirable side of the picture. But human nature is not consistent and occasionally someone will be found who believes that the budget is only an annoyance; that it is intended to be another method of restriction to bring expenses below a level which is already sub-standard and therefore any budget should be strongly opposed. One such individual was "too busy" when asked to prepare a budget for his department for a six months' period in advance. Without making an issue of the matter an estimate for his department was prepared by the accountant on the basis of previous receipts and expenditures. Two or three months later this department head made a request that an increase be granted in the salary of one of his assistants. When he was informed that this could not be done because no provision had been made for it in the budget, it did not take long to convince him that a new scheme of things had been adopted and it would be well for him to adjust himself to the march of progress.

The cooperative attitude may be well maintained by placing in the hands of each department a monthly statement comparing the actual income and expenditures with the budgetary figures. These may be prepared in simple form by providing a sheet showing the classification of the various items according to the budget with a column for the figures of each month covered by the period involved, as shown in Table III.

Any unusual variations from the budget amounts should be personally explained to the superintendent by the proper officials, including any considerable reductions as well as increases in expenses. One is just as important as the other. Where praise is due it should be given. On the other hand, expenditures in excess of the budget should not be lightly passed by. Particularly after the first six months, a sufficient period on which to demonstrate the soundness of the estimate, the budget should be actual and overruns should not be permitted unless they are justified in a most convincing manner. The statement that "the approved budget should become the official financial program for the ensuing year and it should be the definite rule that every department must keep its expenditures within the budget appropriation" holds a great truth.

If this principle be disregarded a large part of the budget's value is lost. Yet the rule should not be so strictly enforced as to interfere with the efficient operation of any department. A budget should make toward rather than hinder progress. If improvements in the service can be made which were not contemplated at the time the budget was prepared and are approved when tested by sound business principles, the budget should be revised to take them into consideration. Otherwise comparisons of results on the new basis with the old estimates would be valueless and confusing.

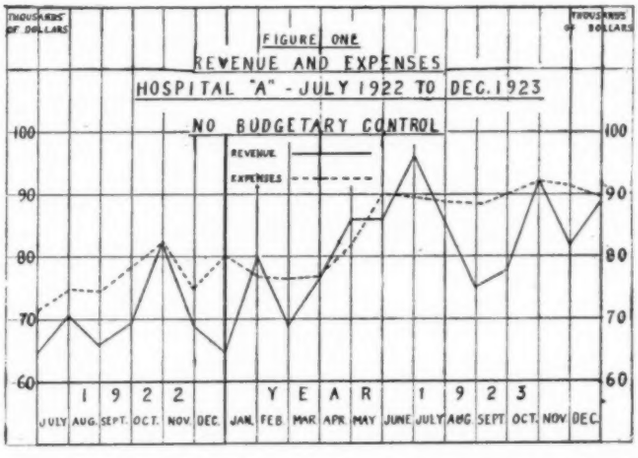
After a budget has been in operation for a period of time it will be profitable and advisable to make revisions and improvements when the figures for succeeding periods are prepared. The Post-Graduate Hospital, in preparing its semi-an-

PROPOSED BUDGET FOR SIX MONTHS ENDING DECEMBER 31, 1924. DIETARY DEPARTMENT.

Classification of Expenses.	Budget Last 6 mos. 1923	Average Expenditures 1923	Budget Last 6 mos. 1924	Increase Over 1923 Expenditures
Salaries	$3,200.00	$3,300.00	$3,340.00	$40.00
Milk and cream.....	2,000.00	1,925.00	2,000.00	75.00
(Other items of expense in accordance with the accts.)...	.....	.....	.....	.....
Total				

nual budget, now makes a comparison with the budget for the similar period of the previous year and with the department's actual figures, as shown on the opposite page.

It will be noticed that the last column shows the increase or decrease in comparison with the actual results for the previous year. The previous budget figures are inserted for the purpose of presenting to the superintendent and finance committee a more complete picture, though it is thoroughly understood that the figures as shown by the books are of more value under normal conditions than the estimate for the previous year.



From the foregoing it should be apparent that in comparison with the advantages, the labor involved in the preparation and intelligent operation of a budget for a hospital is comparatively small so that there is no sound reason why the method should not be generally followed. All the logic of the situation appears to be on one side of the question. Those, who through custom or unfamiliarity with the modern method dislike to accept it, would probably remain unconvinced after listening to or reading a lengthy exposition of the many benefits which may be obtained. But an actual and sincere attempt to test the value of budgetary control will almost invariably prove that the advocates understate rather than overstate the advantages.

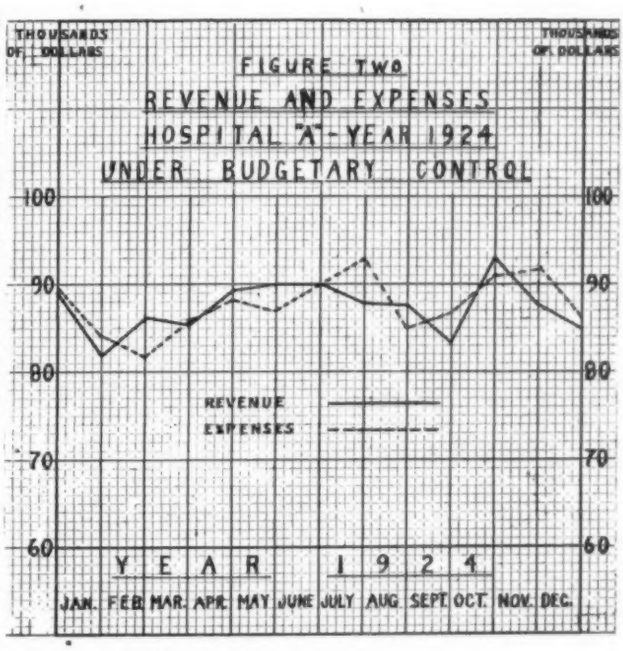


Figure two pictures the actual result during 1924 at the same hospital whose operations are charted in figure one.

Graphs Show Worth of Budget System

It is evident that under almost identical conditions without budgetary control there was a wide fluctuation in receipts and expenditures, with disquieting deficits in some months, while under budgetary control the lines are fairly parallel. A study of these two figures can lead but to one conclusion. If you desire to travel a path well charted in advance, avoid financial pitfalls, be encouraged along the way by the cooperation of associates, and finally to gain financial success, budgetary control points the way. If you wish to proceed in the dark, uncertain as to where you are headed and constantly worried about financial dangers and difficulties, refuse to turn on the searchlight and thus save the cost of some additional study and work. But the apparent economy will eventually prove a delusion and the possibility of utmost success will have been lost.

COMPARATIVE STATEMENT OF PATHOLOGICAL LABORATORY BUDGET AND EXPENSES FOR SIX MONTHS ENDING JUNE 30, 1924.

	Monthly Budget	ACTUAL EXPENSES.							Six Months' Budget	Decrease from Budget
		January	February	March	April	May	June	Six Months' Total		
Salaries	2,481.66	2,538.52	2,486.68	2,486.68	2,475.85	2,490.02	2,376.68	14,854.43	14,889.96	35.53
Instruments, supplies and equipment	400.00	217.29	166.31	357.48	457.07	381.34	222.20	1,801.69	2,400.00	598.31
Miscellaneous	25.00	8.80	4.00	26.50	21.35	10.65	13.50	84.80	150.00	65.20
Total	2,906.66	2,764.61	2,656.99	2,870.66	2,954.27	2,882.01	2,612.38	16,740.92	17,439.96	699.04

THE LA SALLE COUNTY (ILLINOIS) TUBERCULOSIS SANATORIUM

By JASON F. RICHARDSON, Jr., Architect, Ottawa, Ill.

LA SALLE County was one of the first to act when the Illinois legislature passed a law making it possible to build county tuberculosis hospitals through a tax levy to be voted by the people at any general election.

The law was passed in 1915 and early the next year, through the initiative of the Illinois Tuberculosis Association, an organization was formed in La Salle County for the purpose of conducting a campaign to arouse the people of the county to the need for a county tuberculosis sanatorium. A petition was filed with the board of supervisors asking that the proposition be placed on the ballots for the general election November 1916.

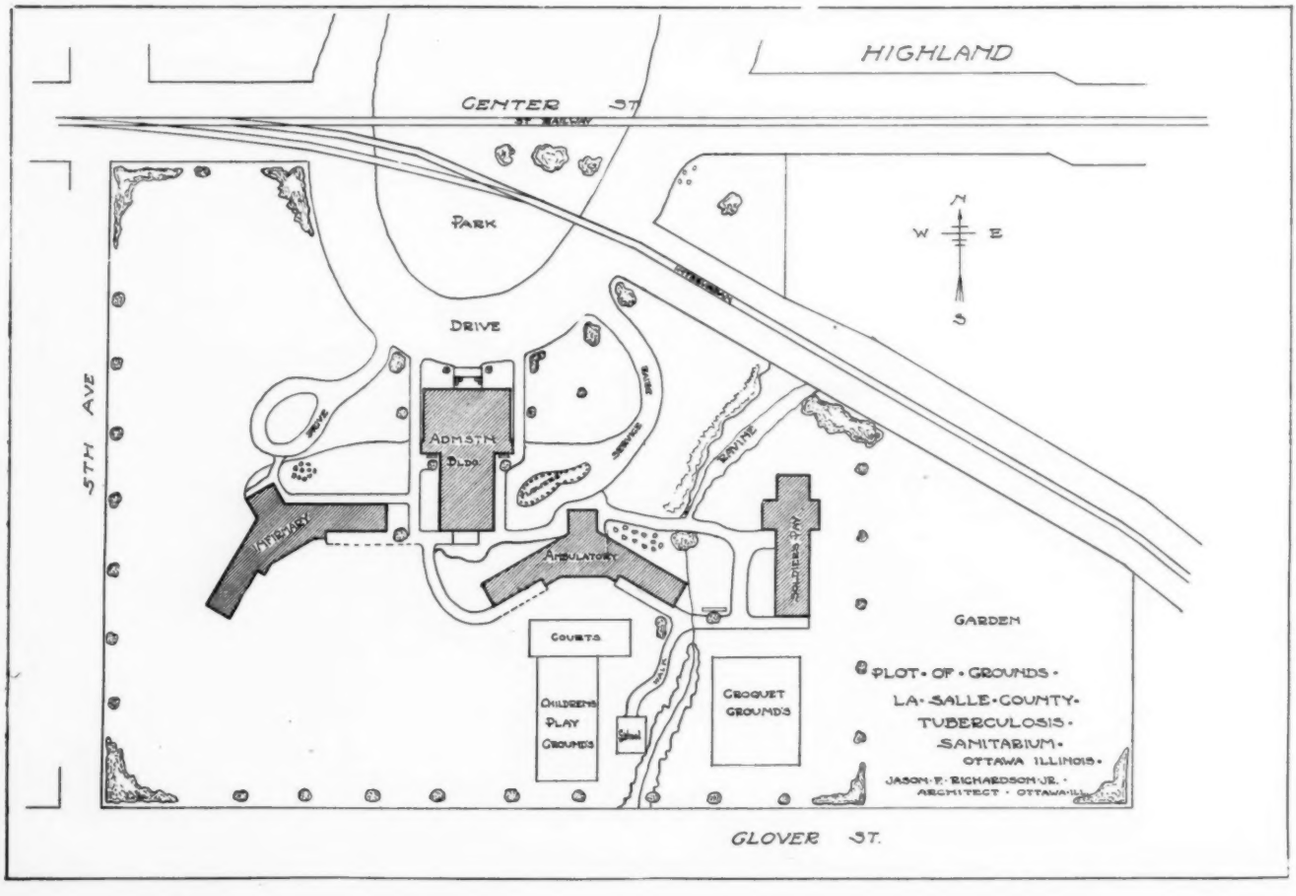
A campaign plan, prepared by the Illinois Tuberculosis Association, was adopted by the local organization. Committees were formed in every section of the county, each working under the direction of the county central committee. Many public meetings were addressed by speakers who woke the people of the county to the need for the sanatorium by pointing out that scores of people were dying annually because they were unable to receive care in a tuberculosis institution. The need for county-wide visiting nurse service in handling the tuberculosis problem was forcefully presented.

The newspapers gave freely of their space, ministers delivered many sermons on this vital subject. Commercial clubs, groups of farmers, and women's clubs discussed it. Thousands of pieces of printed matter were distributed. When informed the public became aroused to the situation.

Public Opinion Expressed at Election

Just how much the public had become aroused is indicated by the following figures taken from the election returns.

Total vote for presidential electors	35,287
Total vote on sanatorium proposition	21,287
Total vote for the sanatorium	15,394
Total vote against the sanatorium	5,893
Total majority for the sanatorium	9,501
Sanatorium majority cast by men	4,449



FIRST FLOOR PLAN SECOND FLOOR PLAN

ADMINISTRATION BUILDING, TUBERCULOSIS SANITARIUM.
LASALLE CO. AT OTTAWA, ILL.
JASON F. RICHARDSON JR. ARCHITECT. SCALE 1/16" = 1'-0"

Sanatorium majority cast by women.. 5,052

Under the provisions of the law, it became necessary for the board of supervisors to name a board of trustees for the sanatorium fund. This board was appointed in December, 1916 and consisted of Dr. Kimball W. Leland, Utica, president; Rev. Dean John P. Quinn, Ottawa, treasurer; and Mrs. Virginia LeRoy, Streator, secretary.

The board of trustees selected Mr. Jason F. Richardson Jr., Ottawa, as its architect and instructed him to prepare preliminary estimates on construction costs, for presentation to the board of supervisors. In the meantime, the trustees ordered that a tuberculosis survey of the county be made by an expert.

This survey resulted in the compilation of a set of tuberculosis statistics that were nothing short of astounding to the lay public. Some of the figures are as follows:

Cases of pulmonary tuberculosis in La Salle County under observation in 1917	214
Cases of pulmonary tuberculosis not under observation	139
Other types of tuberculosis	29
Total deaths from tuberculosis in La Salle County in 1917	56
Cases of suspected tuberculosis	82
Total number of cases of tuberculosis in La Salle County in 1917	520

The survey also showed that 284 persons had been exposed to tuberculosis by living in the same house with patients having the disease in an advanced stage who were regarded as exceedingly careless. In more than two-thirds of the total number of cases uncovered as a result of the survey, it was shown that the patient had become infected through close contact in the home with someone else who had tuberculosis.

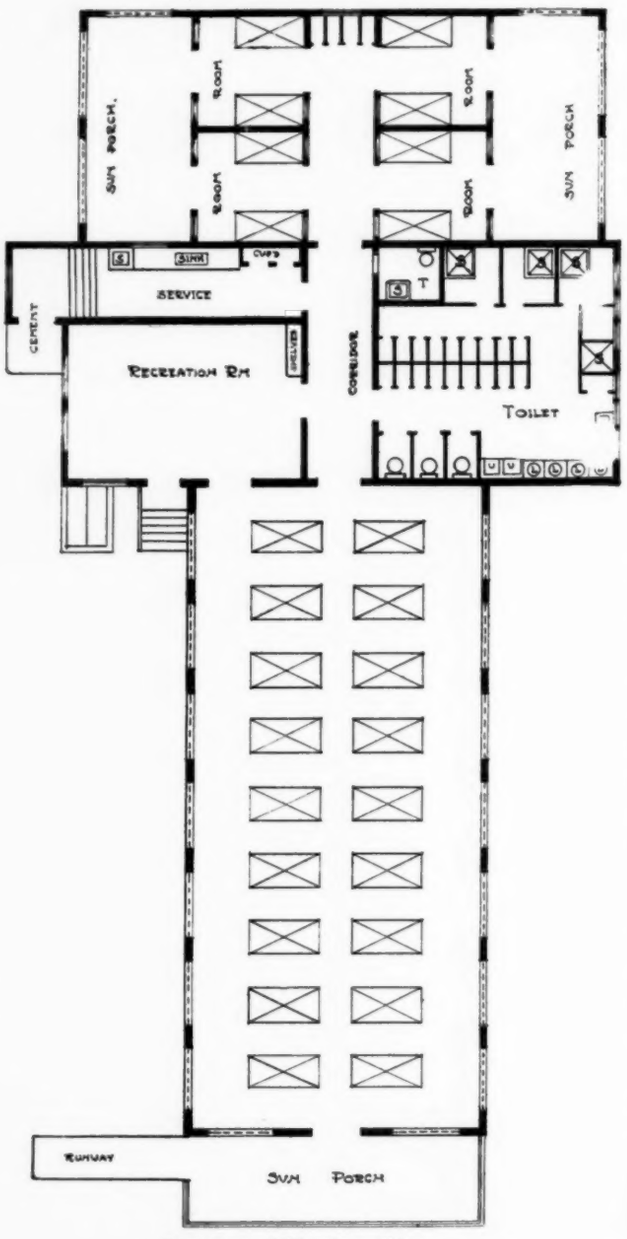
Reports of deaths from all causes in La Salle County, covering a period of several years, were analyzed and it was shown that one out of every ten deaths had been caused by tuberculosis.

The survey also took into account the history of an eight patient pavilion for tuberculosis cases, which had been built upon the grounds of the county almshouse in 1915. Because this pavilion was regarded by the public as a part of the almshouse, practically all of the cases cared for were indigents, yet the demand was so great that often twelve patients were housed in a building which was prepared to handle only eight. Up to September, 1917, a total of sixty-eight cases had been housed in the pavilion, most of them in the advanced stages of tuberculosis.

Both the board of trustees and Mr. Richardson studied other tuberculosis hospitals in many sections of the country and as a result of their investigations, finally agreed upon plans for a building that, in their opinion, would meet the needs of La Salle County.

The law permitted the boards of supervisors to levy a tax not to exceed three mills on the dollar of taxable property. Had the maximum tax been levied in this county the total revenue would have been $117,000. It was agreed, how-

The children's pavilion.



First floor, children's pavilion.

ever, that a two mill tax would be sufficient to erect an administration building large enough for any future need and to construct buildings for the care of patients sufficient for the immediate need. The revenue accruing under a two mill tax was $77,500.

After careful consideration a plot of ground on the high elevation south of the river, adjacent to the city, was purchased. It was found that water, gas and electric supply was available, city and interurban transportation lines passed the grounds, and sewers were only a matter of a few hundred feet.

The administration building is semi-fireproof, of red and black matt faced brick with stone trim, in the colonial style of architecture with massive porches and inviting entrances. Gravelled walks and drives lead to the main entrance. The interior is inviting, with its spacious lobby and colonial staircase ending in the dining room entrance beyond.

The lobby or reception room is spacious, attractive and homelike. Opening from it to the left are the board rooms and offices for the superintendent. To the right are the medical laboratories, dispensary and clinic rooms and office headquarters for the staff. Complete x-ray equipment is here installed.

The living quarters for the superintendent, the nurses and attendants on the second floor, are comfortable and cheerful.

The dining room is a large, high room with beamed ceiling, and pleasing entrances. As it is also the recreation center and is used for all entertainment it is equipped with a stage. The nurses' dining room is entirely separate from that of the help.

The kitchen is adjacent to the dining room and is fully equipped according to the present needs of the institution. This space is made somewhat large to meet the growing demands of the institution. The diet kitchens in the pavilions make it possible to serve the patients their meals in their quarters when necessary.

There are no patients' rooms in the administration building. Three pavilions have been built. The one on the west is for infirmary patients, and is divided into fourteen private rooms for bed patients, with center space for toilets, lockers and utility rooms. The rooms are ten by ten feet with large casement sash opening to the outside and doors of sufficient width to permit all beds to be wheeled to the porches and all connecting rooms. The glass openings of the rooms are of such size that, when open, they provide an open air room, when the patient is too ill to be wheeled to the

A typical ward of the open air pavilion.

porches. Steam heat is also provided for each room.

Another pavilion, the ambulatory type, is of the same size as the infirmary. This building is for men and women, divided at the center, and has all necessary plumbing and heating arrangements for the patients. The modern ideas of the treatment of the tuberculosis patient, with plenty of rest, fresh air and a contented mind can be fully carried out with the minimum of cost and supervision.

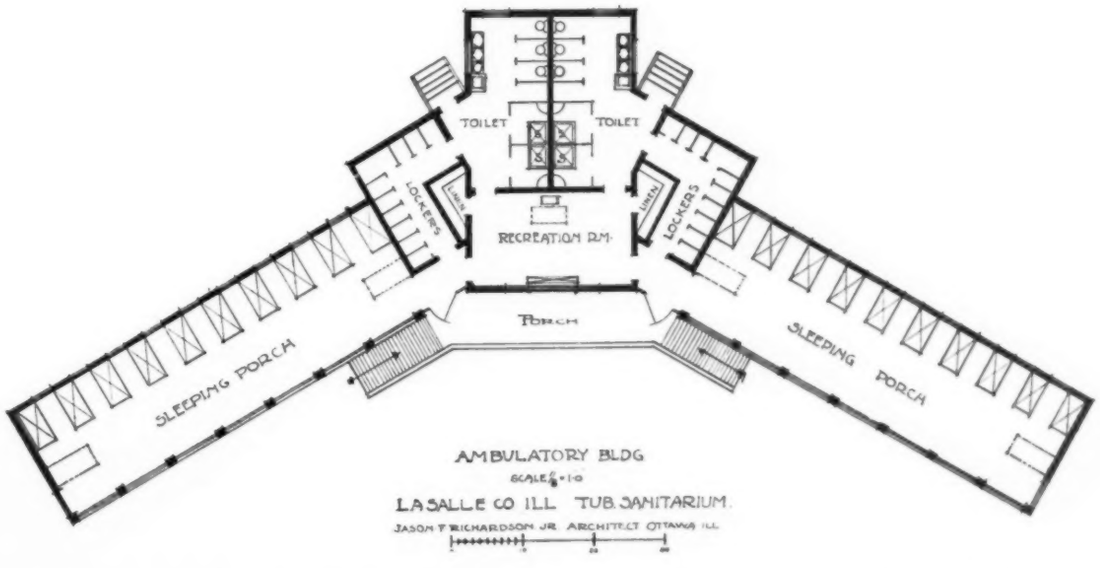
The children's pavilion is a large commodious building with twenty-six beds and all conveniences.

The furnishings are complete in all respects, simple and serviceable, and the institution presents a finished and pleasing appearance. Fire protection is afforded each building by hose reels and fire extinguishers. Electric lights are furnished throughout and all cooking is done by gas. All connections for water, steam, gas, to each building, are in conduits, and all insurance regulations have been fully met.

Provision Made for Expansion

The general plan provides for economical expansion as the sanatorium becomes established. New pavilions for patients can be constructed at a low cost and in line with the development of new methods for treating tuberculosis. The administration building is equipped to meet any demand that may be made upon it for years to come.

It has been and is the policy of the board of trustees so to conduct the sanatorium, that it will come to be regarded by the public in exactly the way that a general hospital is regarded—a scientific institution for the case of any resident of the county who has tuberculosis. The sanatorium is



A corner of the reception room.

not an institution for the poor any more than the public schools are institutions for the poor. Both are supported by general taxation and the sanatorium is for the free use of any person who has tuberculosis just as the public schools are for the free use of all those who desire an education.

It is with some degree of pride that the board of trustees recall that the La Salle County Tuberculosis Sanatorium is the first county sanatorium to be built in Illinois under the law which gave the people the right to vote upon the tax levy for its support. Nothing in the way of preliminary planning and effort has been spared to make this institution, not only a scientific laboratory for the care and study of tuberculosis but an educational center also for the dissemination of knowledge valuable for raising the standard of community health.

PENNSYLVANIA PHYSICIANS' CLAIMS FOR COMPENSATION DENIED

A decision of widespread interest and importance to hospital surgeons and physicians, to the medical profession in general, and to insurance companies, recently reached Easton, Pa., from Harrisburg where it was handed down by Henry Walnut, chairman of the Pennsylvania Workmen's Compensation Board. A copy of the decision, received by David B. Skillman of Easton, counsel for the Pennsylvania Manufacturers' Association, reverses the decision of Referee Seidel given in two cases tried before him at Allentown in April, 1924, and finds against the claims of staff physicians in St. Luke's Hospital, Bethlehem, and the Sacred Heart Hospital, Allentown.

Dr. Walker of St. Luke's, and Dr. Hausman of the Sacred Heart, presented claims of fifty dollars each for the treatment of injured workmen sent to wards in their respective hospitals. The Manufacturers' Association, which would have been compelled to pay, had the bills been allowed, resisted payment in both instances on the ground that a physician or surgeon attached to the staff of a general hospital was not entitled to an extra fee for the treatment of a patient in a general ward in such hospital. The Bethlehem and Allentown doctors held to the contention that workmen's cases should pay a doctors' fee, in addition to the usual charges made to ward patients.

Referee Seidel, after due consideration, allowed the claims of both physicians. The Manufacturers' Association carried the claims to the compensation board and the decision handed down reverses the referee and disallows the claims. The board plainly said that a general hospital staff physician is not entitled to fees for the treatment of workmen cared for in the wards of the institution to which he is attached, and that the payment of such claims would be an added burden to the employer.

In concluding the decision Chairman Walnut said: "In reaching this conclusion we are aware of the interest of the medical profession in the question involved, and are fully appreciative of the importance both to employee and employer of prompt and adequate medical services in the event of an accident, but we believe that the ruling of the board represents a sound interpretation of the act as it is now drawn."

The cases in point were those of Elmer Zimper against H. A. R. Dietrich of Bethlehem, and Milton F. Nagel against F. N. Peters Bros., of Allentown. The decision in no way affects the compensation of these men or any others injured while at work and sent to a general hospital for treatment. The dispute was entirely over the legal right of a staff physician to charge an extra fee for the treatment of an injured workman sent to a general ward in a public hospital.

These cases were not parallel with the one recently decided in the common pleas court by Judge Stotz who awarded a fee to Dr. Paul Correll of Easton for the treatment of an injured man. Dr. Correll was practicing in a private hospital and was held to be entirely within his rights in making a charge for his services. The difference in the cases lies in the fact that one was a claim of a physician attached to a general hospital, while the other was the claim of a physician attached to a private hospital staff.

CONFERENCE ON HOSPITAL SERVICE ADDS TWO MORE AGENCIES

The American Conference on Hospital Service, with which the Medical Department of the Army, the Bureau of Medicine of the Navy, and the United States Public Health Service are already identified, has been strengthened by the addition to its membership of two more governmental agencies, namely, the United States Veterans' Bureau and the National Home for Disabled Volunteer Soldiers.

For the United States Veterans' Bureau the director of the bureau and the medical director will serve as delegates to the conference. The National Home for Disabled Volunteer Soldiers, which conducts branch hospitals and homes in ten states, will be represented in the conference by Col. B. F. Hayden and Col. Vernon Roberts, who are connected with the headquarters of the service in Dayton, Ohio. Gen. George H. Wood is the president of the board of managers of the National Home for Disabled Volunteer Soldiers.

"Jealousy," says Joseph Collins in The Bookman, "instead of being the exaggeration of one of the most uplifting passions of men, is a pathological condition which fits the possessor for a psychopathic ward and an object for a sanatorium."

CARE OF PATIENTS' CLOTHING AT MASSACHUSETTS GENERAL HOSPITAL

By C. E. WELLS, M.D., Assistant Director, Massachusetts General Hospital, Boston, Mass.

WHEN the Mosely Memorial Building, the administration building of the Massachusetts General Hospital was completed in 1916, quarters for a central clothes room were provided in the basement, conveniently located and of ample size to provide storage space for clothing from all the wards. The clothes room is fitted with horizontal rods about seven feet from the floor. Upon them are placed clothes hangers of the type having a crossbar below for trousers and skirts.

The clothing is placed on a hanger and covered by "clothes room bag" (figure 3) as a protection from dust. This bag is made of sheeting, closed at the top except for a small hole through which the hanger hook passes to the rod from which it is hung. The lower end of the bag is not closed but is turned up inside to form two large pockets for shoes and other articles which cannot be hung on the hanger. The hangers are numbered for convenience in checking. The clothes room is a part of the check room provided for general use. It is open daily from 6 a. m. to 7:30 p. m. for such checking. Clothing is received from wards only between 7:30 and 11:45 a. m., and 1:00 to 4:45 p. m., and is delivered to the wards from 7:30 to 11:45 a. m., and 1:00 to 4:15 p. m. A clerk is always in attendance to receive and deliver clothing to the wards and to check wraps for visitors, office employees, medical students, and others.

Property List Signed by Patient

Upon admission to the hospital the patient is sent directly to the ward to which he is assigned. There he meets the head nurse who takes charge of all money and valuables except those he wishes to keep with him in the ward. For such articles he assumes the entire responsibility. The valuables to be deposited for safekeeping are placed in a large manilla envelope upon which the ward is stamped and the patient's name and list of contents written. The property list (figure 1) is made out in duplicate and signed by the nurse and by the patient. This list is printed as a part of the clothes list. The original sheet is perforated so that this copy of the property list may readily be separated from the clothes list, since the two are handled differently. The carbon copy is not perforated, and the two lists remain together as the ward copy of the clothes list. The original property list is detached and sent to the cashier's office with the envelope containing valuables, and is retained there until the patient is discharged. The cashier delivers the envelope to the patient when he pays his bill so that he may check the contents and sign the original copy of the property list which is filed by the cashier. Articles may be withdrawn or deposited by the patient during his stay in the ward. Such deposits or withdrawals are noted on the original copy of the property list with the signature of the nurse or orderly making them.

After parting with his valuables the patient is undressed in the ward bathroom where his clothing is listed in duplicate (figure 2) by the nurse or orderly and signed as correct by the patient. Appropriate lists "for men" and "for women" are used. The clothes are folded and made into bundles by being placed on squares of cotton cloth the diagonal corners of which are tied together, thereby making convenient sized bundles for transportation to the central clothes room by nurse or orderly. Both copies of the list accompany the bundles. In the clothes room the bundles are opened and both lists checked by the clothes room clerk. The original list is filed in the clothesroom, the carbon copy taken back to the ward and hung on the patient's chartboard. The clothing is now placed on a hanger, under a "bag" covering and hung on the rods. The check number on the hanger is entered on both copies of the clothes list. Articles sent to the clothes room during the patient's stay are entered on the back of the list and signed for by the clothes room clerk. Articles removed from the clothes room are signed for by the nurse or orderly receiving them.

Clothes List Filed with Medical Record

Upon discharge of the patient from the hospital the ward copy of the clothes list is taken to the clothes room by a nurse or an orderly. The clothes are checked and the clothes room list signed by the nurse or orderly and returned to the ward where it is attached to the medical record to be sent to the record room where it is filed for six months. The patient signs the ward list when he receives his clothing, and any error noted by the patient is entered on the back of the clothes list which is then sent to the training school office for investigation. A report of the findings is made

MASS. GEN. HOSPITAL
(For Women)

Name .....
Date.... Ward.... Check No...

Bath Robe.....Muffler .....
Bloomers .....Night Gowns...
Boots .....Pajamas .....
Brassier .....Rubbers .....
Chemise .....Scarf .....
Coat .....Shirt Waists...
Combination ...Shoes .....
Corsets .....Slippers .....
Corset Covers..Stockings .....
Drawers .....Suit Case.....
Dress .....Sweater .....
Dress Skirt.....Umbrella .....
Garters .....Under Skirts...
Gloves .....Under Vests....
Handbag .....Union Suits....
Handkerchiefs..Veil .....
Hat .....
Kimona .....

I certify that this is a correct list of clothes.
Signature.....Pt.
(If patient cannot sign nurse shall here state why)
.....Nurse
.....Orderly

Clothes Room open 8:30-11:45; 1-4:30; 5:30-7.
Date.....Clothes as above listed
Received by.....
Clothes Room Clerk

Date.....Clothes as above listed
Returned to.....
.....Nurse
.....Orderly

PROPERTY LIST
(Money, watches, keys and other valuables)

Name..... Date.....
Cash..... Withdrawals.....
.....

I certify that above is correct list of my property.
Signature.....Pt.
.....Nurse
.....Orderly

Date.....Property as above listed
Received by.....
Patient

Missing articles must be immediately reported to head nurse and noted on back of slip.

MASS. GEN. HOSPITAL

Ward..... Date.....

I take the entire responsibility of retaining in my own possession the following articles:
.....
.....
.....
.....
.....
.....

Signed .....
Patient
Signed .....
Nurse
(Explanatory Note)

WOMEN'S CLOTHES LIST

Showing the original clothes list and property list and the back of the carbon copy.

Note that the property list may be detached from the original copy along the perforated line, but not from the carbon copy which is kept intact on the ward, and later filed in the record room.

These lists are furnished in blocks of 50 for convenience in using.

Figure 1.

to the director who adjusts the matter with the patient.

In the case of infants and children brought by their parents or some responsible person, the clothing is sent home to be returned when the patient is ready to be discharged.

In the emergency ward locked steel hampers are provided for the temporary deposit of clothing of patients undressed there. If the patient remains in the emergency ward only a few hours nothing further is done with his clothing. If he is admitted to a hospital ward, the usual procedure is followed. The clothing is then listed and taken to the clothes room by an emergency ward nurse or orderly, the ward copy of the list being sent to the ward to which the patient is assigned.

When a patient dies the ward copy of the clothes lists is endorsed "Allen Street house" (the morgue) and sent to the clothes room where the list is checked and returned to the ward and the clothing delivered to the undertaker.

Private Patients May Retain Valuables

Patients in single rooms may retain their clothing and valuables if they wish to assume the responsibility for this care. In this case no list is made. The patient signs the "responsibility" blank on the back of the clothes slip which is filled in to read: "I take the entire responsibility of retaining in my own possession all my clothing and valuables." If he does not wish to retain any articles they are listed and sent to the cashier or

(*Continued on page 513*)

MASS. GEN. HOSPITAL
(For Men)

Name .....
Date.... Ward.... Check No...

Bath Robe.....Neckties .....
Belt .....Night Shirt....
Boots .....Pajamas .....
Caps .....Rubbers .....
Coats .....Shoes .....
Collars .....Slippers .....
Day Shirts.....Stockings .....
Drawers .....Suspenders ....
Flannel Shirts..Sweaters .....
Garters .....Trousers .....
Garters, Sleeve.Trunks .....
Gloves .....Union Suits....
Handkerchiefs..Valises .....
Hats .....Vests .....
Mufflers .....

I certify that this is a correct list of clothes.
Signature.....Pt.
(If patient cannot sign nurse shall here state why)
.....Nurse
.....Orderly

Clothes Room open 8:30-11:45; 1-4:30; 5:30-7.
Date.....Clothes as above listed
Received by.....
Clothes Room Clerk

Date.....Clothes as above listed
Returned to.....
Patient

PROPERTY LIST
(Money, watches, keys and other valuables)

Name ..... Date.....
Cash..... Withdrawals.....
.....

I certify that above is correct list of my property.
Signature .....Pt.
.....Nurse
.....Orderly

Date.....Property as above listed
Received by.....
Cashier

Missing articles must be immediately reported to head nurse and noted on back of slip.

MASS. GEN. HOSPITAL

Ward..... Date.....

I take the entire responsibility of retaining in my own possession the following articles:
.....
.....
.....
.....
.....
.....

Signed .....
Patient
Signed .....
Nurse
(Explanatory Note)

CLOTHES LIST FOR MEN

Printed alike on both sides of the sheet. This portion is folded to the left and a carbon sheet inserted so that a carbon copy is made.

This portion is the back of the original copy, that on the left is the carbon copy. Valuables to be retained by the patient on the ward are listed in the space above.

Note the property list below which is perforated at the top to allow it to be detached from the upper part, their destinations being different. The detached property list is taken to the cashier's office with the valuables to be filed there. It is checked and signed by the patient when he is discharged and is then filed in the cashier's office as a permanent record.

The check number at the top is the clothes room hanger number and is entered on both copies of the clothes list.

Figure 2.

HOSPITAL NOISES AND HOW TO MINIMIZE THEM*

By EDWARD F. STEVENS, F.A.I.A., Stevens and Lee, Architects, Boston, Mass.

WHEN asked to prepare this paper I recalled the complaints and criticisms of hospitals which have come to my attention and it seemed that the greatest complaint was in regard to hospital noises, with such reports as—"Our new building functions finely but it is so noisy." I have thus taken as my subject "Hospital Noises and How to Minimize Them," and I'm going to tell you some of my own observations in the hope that it will provoke discussion.

Noises which produce unpleasantness in a hospital are from two sources, those which occur outside the building and those which are produced inside the building.

The outside noises may be noises of traffic, such as noises of street cars, noises from the automobile horn, noises from the starting of automobiles, and I was almost going to say in this day of the aeroplane, noises from that source. At present, however, the aeroplane is not used to such an extent that we must put a sign in the top of our chimney for the aeronaut to read as he passes by—"Hospital Zone! Shut off the motor while passing!" But with the street traffic the hospital zone signs placed on the street near the hospital should warn the ordinary motorist to be considerate of the noise produced by his motor.

In the case of a hospital in the vicinity of railroad tracks, it would seem that intelligent directions by those in authority could be given engine drivers that in passing certain hospital locations due care should be used to refrain from inordinate blowing of whistles and ringing of bells. American locomotives are among the noisiest in the world. In Europe one rarely hears a locomotive start, but in this country, like the hen, they announce their presence with an everlasting racket.

The street cars, with their grinding and shrieking on curves, and on poor tracks, make night hideous. Only a carefully graded and ballasted road bed is needed to minimize these sounds.

In locations where there are many horse-drawn vehicles, wooden pavements could be used in the street; but I believe that the ordinarily intelligent driver, whether of a horse-drawn vehicle or of a motor, should consider the hospital zone sign of warning against undue noises.

Perhaps one of the greatest complaints that comes to me from the patient is in regard to the noise occasioned by the parking and consequent starting of the motors near the hospital. We must accommodate the visiting doctor with a parking place reasonably near the hospital but this does not mean directly under the patient's window; and if the parking place is at a little distance from the hospital, very much of the unpleasant noise from the motor is eliminated. Even doctors are sometimes thoughtless when they are in a hurry.

The unpleasant and annoying sounds from the inside of a hospital, which disturb the patient's state of mind, emanate from various sources, such as steam pipes, plumbing pipes, dishwashing, bells and signals, clicking of door latches and slamming of doors, the rattling of windows, the patients talking among themselves, which would react upon the more nervous patients, thoughtless visitors walking and talking in the corridors.

How to prevent or at least how to minimize these annoying features of hospital service is the problem before us.

The noise from steam pipes is one the engineer should solve in his layout and should see that no "pockets" occur in the piping, that the pipes are properly graded, and then that the attendant is instructed properly to control the system by the

Noises Out- And Inside

"PERHAPS one of the greatest complaints that come from the patient is in regard to the noise occasioned by the parking and consequent starting of the motors near the hospital. . . If the parking place is at a little distance from the hospital, very much of the unpleasant noise from the motor is eliminated. "The unpleasant and annoying sounds from inside the hospital, which disturb the patient's state of mind, emanate from various sources, such as steam pipes, plumbing pipes, dishwashing, bells and signals, clicking of door latches and slamming of doors, the rattling of windows, the patients talking among themselves which would react upon the more nervous patients, thoughtless visitors walking and talking in the corridors. How to prevent or at least how to minimize those annoying features of hospital service is the problem before us."

*Read before the New England Hospital Association.

valves. And right here may I say that I think every nurse should have, as part of her training, instruction in the care of the mechanical equipment of a hospital.

Elevators and stairways, if placed in the open, are generally a source of disturbance. It is desirable, therefore, to shut these off from the main corridor by means of an additional door, which makes for privacy and serves as a sound deadener. If we have a maternity department, the delivery rooms and babies' rooms should have a separate section shut off from the patients' portion.

While the serving kitchen, the sink room, and the toilets are sources of noise, if they are cut off or entered from a recess around the corner, as it were, the noises will be greatly diminished, for sound, like light, travels more readily in a straight line and is deadened by deflection.

Much of the disagreeable noise from discharging plumbing fixtures is attributable to poor selection of material, poor installation, thoughtless supervision, or sometimes to high water pressure not properly reduced. Every plumbing fixture should have a shut-off valve which should be kept properly adjusted.

Signals Need Not be Noisy

Bells, telephones, nurses' and doctors' calls are indispensable to the modern hospital but can be made to function perfectly and quietly; the electric light signal has largely taken the place of the audible signal for nurses' and doctors' calls; the telephone and other bells can be low-toned gongs, which will not disturb the most sensitive ear; the doctor's call may be either a light with numerals, or the simple telegraph call or muffled bell, scarcely audible to the patient in bed but distinguishable by the person called.

Signs in the hospital corridor or cards asking the visitor to consider the comfort of the patient are all helpful in procuring the desired end. One hospital uses a card on one side of which is the permit to visit a certain patient and on the other this admonition—

"*BE QUIET.* Speak softly; walk lightly. Sick people will appreciate it."

One of the most noticeable and preventable noises is the clicking of door latches. To prevent this one sees the doors muffled or "muzzled" with a towel or even a patented rubber "gag." Why should we not omit the latch and substitute a checking spring on all doors between corridors and patients' rooms and so remove this source of noise? Then with the substitution of the "hook handle" for the knob, the door may be opened from either side without the use of the hand.

The construction of the building plays a great part in the quietness or the noisiness of the hospital and, strange as it may seem, the better the construction the more noisy the building becomes. For with concrete and steel frame, hard plaster walls and ceilings, tile or cement floors and solid doors, all of the surfaces become sounding boards. For hygienic reasons our walls should be fairly free from draperies, tapestries and broken surfaces and finished with hard plaster or tile surface. It is possible, however, to break up too long corridor surfaces by the recessing of door openings, thus gaining a double advantage of enlarging the corridor at the entrance to the rooms and breaking up the surfaces.

Noises which prevail because of the type of construction of the building are perhaps the hardest to correct.

The sound from room to room is most annoying, for a patient is quite well satisfied with his own symptoms without hearing all about the symptoms of the patient in the adjoining room through the fireproof but not soundproof partition, or from the corridor or utility room through improperly built partitions. Careful experiments have been made to find a material for hospital partitions which will prevent the transmission of sound from room to room. The results of experiments in music studios and other buildings are available for our use in hospitals.

How to Avoid Room to Room Sounds

Sound transmission from room to adjoining room can be prevented by the use of deadening materials between the upright supports, but this is expensive and requires much additional space. More recent experiments show that by using a two-inch solid plaster wall between rooms not only are satisfactory results obtained but a decided economy in construction and much room are gained; for with a building, say 200 feet long, with ten cross partitions, which with tile construction would take fifty inches or sixty inches of length, the two inch solid partition would take but twenty inches. This would make a saving of thirty to forty inches in length of the building and at the same time would give a reasonably soundproof protection.

But this construction, while it minimizes the sound transmitted through the walls, acts as a sounding board to those in the room so that some material is needed to absorb the same. The mattress, the bed clothing, the window draperies and the furniture all help.

Echoes in Fire-Resisting Buildings

In the corridor, however, there is very little of an absorbing nature and our greatest complaint in a fireproof building is this echoing and re-

echoing of the sounds wherever produced. Conversation, the rustle of the nurses' skirts and even the slightest noises are magnified.

Perhaps right here is our greatest trouble, and if we can either confine or absorb the noise when and where it is produced, or present some intervening space where the same can be absorbed, we can very largely prevent its annoyance to others. This can be accomplished to a large degree by placing on the ceilings of the corridors and the noisy rooms an absorbing material with what Professor Sabin termed "inter-communicating cells." The result, however, is most marked, for the voice or other noise produced in the ward, in the room, or in the corridor, is immediately softened as it passes the corridor, and all echoes are stopped at the source. To illustrate the effect of this material, snap a piece of starched linen and an audible sound is produced. This starched linen would represent the hard plastered wall. Snap with the same strength the same linen unstarched and no sound is produced as the force of the blow is absorbed. This would represent the absorbing material. It becomes a scientific study for the acoustical engineer to tell us the thickness of the sound deadener which will minimize all echoes. This material used on the ceilings is unnoticeable and may be colored the same shade as other ceilings or walls.

Uncovered Floors Source of Noise

The quality of the floors, too, makes for a quiet or noisy hospital. If floors are of wood, cement, or tile, every footfall adds to the noise, so that if a soft carpet is used, as in hotels, the noise is greatly minimized. But for hygienic reasons this cannot be done in hospitals, so that we resort to cork tile, linoleum, and rubber surfaces, thereby checking the noise at the start.

While sound deadening is important to the well being of a hospital, even this can be carried too far. We must not make the hospital "as silent as a tomb." Sound waves like light waves are essential to health, so that it is the annoying and irritating sound waves we should endeavor to minimize. I believe that in our future hospitals the acoustical engineer will play as important a part as the heating and electrical engineer.

MANY FOREIGN DELEGATES PLAN TO ATTEND A. H. A. MEETING

Representatives of twelve foreign countries have signified their intention of attending the twenty-seventh annual convention of the American Hospital Association to be held at Louisville, Ky., the week beginning October 19, 1925. Delegates are expected from Cuba, Honduras, Mexico and many of the South American Republics, as well as from Great Britain, France, Spain, Belgium, Germany, China, Australia and New Zealand.

CARE OF PATIENTS' CLOTHING AT MASS. GENERAL HOSPITAL

(*Continued from page 510*)

CLOTHES ROOM BAG

Made of sheeting, 36 by 60 inches. The bottom turned up to make a pocket 14 inches deep. A slit 3 inches long at the top to go over the hanger. Open at the bottom. A pocket may be made in back as well as in front if so desired. Pockets open inside.

Figure 3.

clothes room in the usual way. The list of articles retained is then recorded as in any case.

When it is necessary to wash or fumigate a patient's clothing it is done from the ward before sending the clothing to the clothes room. The articles to be washed are sent with the ward laundry and returned to the ward where they are bundled and sent to the clothes room in the usual way.

In the Phillips House there is no restriction upon the articles which the patient may bring. He occupies a room and the hospital does not assume responsibility for its contents. No attempt is made to list or otherwise care for the patient's property, except that he may deposit valuables in the vault in the cashier's office.

SIMMONS COLLEGE OFFERS SUMMER COURSE IN SOCIAL WORK

Two six weeks' courses in medical and psychiatric social work will be offered by Simmons College, Boston, Mass., from July 8 to August 19. The institute is designed for workers of experience and the course will offer group discussions, lectures and observation of actual work of departments in Boston hospitals. Applicants are required to have had at least two years of experience as social workers in either the medical or psychiatric fields. Those who desire to apply for admission are asked to write to the Simmons College School of Social Work, 18 Somerset street, Boston.

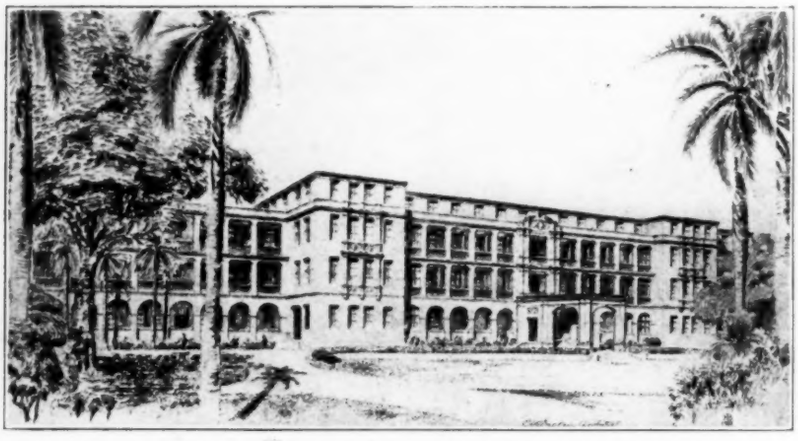
It is quite needless to dissertate upon the value of books while trying to set forth the benefits to be derived from a circulating library in an institution, especially a hospital. Books are the greatest mental stimulant in the world. They open to the reader the thoughts, the experience, the lives of others. By their guidance one can live outside oneself and reach beyong the limitations of one's own small person.—Dorothy M. Hopkins in The *Canadian Nurse*.

From the almost universal reports of baby parties as the outstanding feature of National Hospital Day, it would seem fitting that May 12 and National Baby Day should become synonymous.

MODERN STRUCTURE REPLACES OLD QUEEN'S HOSPITAL, HONOLULU

By C. W. DICKEY, Architect, Oakland, Cal., and R. G. BRODRICK, M.D., Consulting Expert, San Leandro, Cal.

THE design of the new Queen's Hospital, Honolulu, is simple and dignified in the Spanish Renaissance style of architecture with broad lanais suitable to the Honolulu climate. Bright colored awnings, hand painted and treated by a fireproofing process, add a gay touch to its appearance. A raised terrace across the front of the main building give it a fine setting and provide an easy approach for automobiles and ambulances. The main entrance is through a central porte cochère with auxiliary entrances at the end of the new building which is



Front view, the new Queen's Hospital, Honolulu.

220 feet long and four stories high. The old wooden porches have been removed from the Pauahi wing and replaced with reinforced concrete porches in keeping with the new building.

The exterior is finished in light colored cement stucco with touches of red tile on the tops of the walls. The sashes and iron railings are finished in dull green. Plans for the new building were worked out by the architect, C. W. Dickey, collaborating with Dr. R. G. Brodrick of California.

The old coral administration and ward building known as the Queen Emma wing has been torn down and replaced with a four-story modern fire-proof building which is in every sense an up-to-date hospital. The principal things that differentiate a modern hospital from a mere hotel with nurses is the scientific work exemplified in the surgery, laboratory, x-ray and special culinary departments. All of these are provided in the new building, and the private rooms and wards are most admirably arranged for service and are equipped with many conveniences never before seen in the Islands.

On the first floor are the administrative offices including the main office, offices for the superintendent, head nurse, and house physician, room for visiting staff, library and conference room, drug room, lavatories for men and women and a receiving and emergency department including a social service department. Here ward patients are received and prepared for operation or, if instant attention is necessary, are operated on. Occasionally cases are received in this department which prove to have communicable diseases and hence cannot be admitted. For their accommodation, isolation rooms are provided with their own diet kitchen and other conveniences. In this department are located rooms for mental and other noisy cases. The main diet kitchen for the whole hospital is also located on this floor.

The basement is well lighted by area ways and contains rooms for storage, sterilizing, linen, soiled linen, patients' clothing, drugs, etc.

The second floor is devoted to women's wards with conveniently located service rooms, such as lavatories, nurses' stations, utility, linen, treatment, laboratory, and for the janitor. Everything is planned for the most efficient service possible, all unnecessary steps on the part of the nurses being eliminated.

Wards are so arranged that each gets the full sweep of the trade wind and also the southerly wind, having complete cross ventilation. There

A view of the grounds showing nurses' home in the background.

are thirty-five beds on this floor included in wards of various sizes, and several rooms for the very sick or dying and for those who are noisy or delirious or should be isolated for other reasons. There is also a nursery so that the babies may be kept close to their mothers.

Elevators and stairs are located at both ends of the building, but the wards are served principally by those at the southeast end, while the private patients use those at the opposite end opening on to the porches that connect the Pauahi and Bishop wings.

The pavilions at the ends of the building contain the utilities, all the wards being on the northeast side while across the front between the pavilions is a sixteen-foot lanai (veranda) for the use of convalescing patients. Another large lanai is located at the southeast end of the building.

Third and Fourth Floor Plan

The third floor is devoted to twelve private rooms. They are all located on the northeast side with full cross ventilation, and each room connects direct with a toilet and shower bath and has its own clothes closet and wash basin.

In the pavilions at the ends of the building in the front are the service conveniences similar to those on the second floor, and the lanais are also similar with an additional lanai in the rear occupying the space between this building and the Bishop wing. Back of this lanai is a diet pantry for the use of all private patients in all wings of the hospital.

The fourth floor is devoted entirely to surgery and this floor is the delight of the medical profession. Every convenience has been studied with extreme care to give the most efficient service and the equipment is most modern in every way. There are two major and one minor operating rooms, with a fourth operating room that can be darkened for eye, ear, nose and throat work. There are four recovery rooms for ward patients who are held in these rooms until entirely recovered from the anesthetic before being taken to the wards.

The operating room is lighted by side windows and skylights and electrically lighted by powerful deflectors arranged above the ceiling so as to give a diffused light for night work.

At one end of this department is located an excellently equipped x-ray department with a large room where pictures are taken, a fluoroscopic room, a treatment room, a dark room, a store room, and waiting, dressing and toilet rooms for patients. X-ray machines are enclosed in a sound-proof room, and a lead-lined booth for the operator is provided.

Entrance to the grounds of the Queen's Hospital.

At the opposite end of the building is located the laboratory, well-lighted and equipped with every convenience and facility for the scientific work.

Among the general features of the hospital that make it strictly modern are the following. All cases, refrigerators, and such equipment are built in flush with the walls. Floors in general are of cement covered with linoleum, special floors such as operating rooms, baths toilets, utility, treatment and other rooms where water is used being of tile. In the operating rooms the floors and walls to a height of five feet are of light grey tile. The door frames, casings and much of the trim are of steel. The doors are of birch stained to a dark mahogany color and built without panels. Many of the doors are glazed with clear plate glass in the upper half. Double acting doors are fitted with cork kick-plates let in flush with the surface of the door. A projecting rounded base is provided in all rooms to keep the furniture away from the walls. The walls in general are of painted hard wall plaster.

There is a ventilating system to exhaust the air from the operating rooms, utility rooms, toilets, diet kitchens and other places where odors originate.

The surgery on the third floor of the Pauahi wing has been remodeled and used for private rooms and for a well equipped maternity department.

The men's wards are located in the temporary ward building in the rear of the Pauahi wing until such time as a new wing can be added at the right end of the new building.

THREE A. M. IN THE HOSPITAL

It's 3 o'clock in the morning,
I've been busy the whole night through—
Emergencies, lights and babies
There's never a respite, 'tis true.
Daylight soon will be dawning,
The temps must be taken too;
I could go right on forever—
But I'll be darned if I do.—

The *Raven*, published by the nurses of Ravenswood Hospital, Chicago, Ill.

CONCERNING HOSPITAL DEATHS

By H. E. ROBERTSON, M.D., Head of Section on Pathologic Anatomy, Mayo Clinic, Rochester, Minn.

WHEN a patient consults a physician an automatic contractual relation becomes effective immediately. The patient tacitly agrees to submit his history and his person to the physician and eventually, as an expression of the value of service rendered, to pay a reasonable fee. The physician, on the other hand, agrees to devote his knowledge and skill to diagnosing correctly and treating wisely his patient, or advising him with respect to his ills. So universally admitted is the force of this relationship that it is not only recognized as necessary by the profession and its clientele, but also has become established in courts of law, the world over. Since this unwritten contract is partly legal, partly moral and wholly rational, deliberate breaches of it are not common.

With the hospital, a quite similar contract is assumed, and its acceptance by both parties is largely taken for granted on both sides. The only real difference is that the hospital is an organization and as such assumes responsibility for all the acts of its various component members all of whom, in a certain well-defined degree, are a part of the physician's side of the case. Thus there must develop, on the part of the hospital organization, a certain spirit of service, an esprit de corps, which may be defined as teamwork, which contributes largely to its reputation and hence its support. The successful establishment of such a working unit involves many details of hospital management, the discussion of which is beyond the province of this paper. My theme is concerned with that portion of the hospital routine which has to do with patients who may die in the hospital.

Moral Obligation of the Physician

A fundamental principle, which must be fully recognized and freely admitted, and without which this portion of the hospital activities will surely fail, consists in the moral obligation which always and automatically rests on any physician or group of physicians in whose practice a death may occur. This obligation rarely may be considered a legal one; as a rule, no human agency is to blame because a patient dies. Death is a matter which, in the vast majority of cases, lies beyond human control. For all that, I repeat, that every death occurring in a hospital places the hospital under a definite debt to humanity, and the measure of the recognition of such a debt largely marks the standards of that hospital's ideals of scientific achievement and material progress in the care of its sick. The character of this debt, a sort of moral addenda to the contractual relation already mentioned, has its basis in the unwritten guarantee that is given by every medical agency having the responsibility of the care and cure of disease. This guarantee embodies the promise that every known measure possible will be wisely employed in diagnosing and treating each patient, and includes the application of any useful knowledge gained either inside or outside the hospital. The sum total of all this armamentarium must be continually augmented and perfected, not only by reading and travel, but also by experience.

Obligation Not Ended

"WHILE death ends the formal record of the patient's hospital residence, his death should constitute, as a rule, the most valuable experience obtainable. There has been a failure, probably justifiable, but nevertheless a failure, to preserve life and health. A real obligation rests on the hospital as an institution to make immediate inquiry into all the facts surrounding the care of this patient and to acquaint those concerned with these facts and their bearing on future patients."

Contact with the sick is a most valuable experience, and every member of a hospital staff should be the richer in ability to practice medicine for every patient admitted to the hospital. If a patient dies, the experience at once assumes major importance. While death ends the formal record of the patient's hospital residence, his death should constitute, as a rule, the most valuable experience obtainable. There has been a failure, probably justifiable, but nevertheless a failure, to preserve life and health. A real obligation rests on the hospital as an institution to make immediate inquiry into all the facts surrounding the care of this patient and to acquaint those concerned with these facts and their bearing on future patients. Again, I repeat, the measure of the recognition of this obligation by any hospital is the measure of the real achievement of that hospital in the domain of scientific medicine. No other criterion furnishes such val-

uable evidence of the sincerity of an institution's attitude toward its main task, the alleviation of suffering and the prolongation of life.

Case Incomplete Without Autopsy

In the course of such an inquiry the written records of the case and the testimony of those who came in contact with it, are valuable data, but the cap sheaf is formed by the facts that may be collected through careful post-mortem examination, and a thorough study and interpretation of the findings by a trained and competent pathologist. There is no worthy substitute for this method of acquiring medical knowledge, and without it the final record of any given case must be indorsed in effect with this statement: "No autopsy obtained. To this extent the case is thereby forever incomplete."

No extended argument of the thesis just proposed would seem to be necessary, if repeated and long-continued attempts to impress its importance had not met with such an inertia of *laissez faire*, as almost to discourage the valiant efforts of the few who are holding the front line. The physicians of the staff of an institution are the ones who are largely to blame. As a rule the executives are willing to go farther than the physicians. Many physicians do not desire to have their deaths questioned, and are at least passively unwilling to permit a searching post-mortem examination and a discussion before their colleagues of all the findings in the case. Such discussion would reveal valuable information, but at the same time would question their conduct in the cases. It is not an easy test, often it proves to be very hard, and the struggling practitioner cannot always be certain that mercy and justice will color all of his critic's judgments. But the future progress of medicine, and the standing of the profession in the eyes of the public demand, with increasing vehemence, that the physician shall practice his art honestly and to the fullest extent of his ability with the aid of his associates, and that he shall be willing and eager to face a survey of his cases, if for no other motive, than to profit the most from the patients under his supervision.

Extended Review of Every Death Needed

Once the principle of the extended review of every death is established as one of the real functions of the hospital, permission to make post-mortem examinations will follow in an increasing percentage of cases. The machinery for obtaining permissions and carrying out the examinations will not be discussed here. The procedure must naturally be modified to conform to the size and composition of the staff and other characters of each particular hospital. That it shall, according to the circumstances, carry out the proposed procedure to the fullest possible extent is all that can be demanded. Once a desire to have a real clinicopathologic conference is aroused and approved, once the services of a competent pathologist are obtained, the details of bringing about a satisfactory meeting are fairly easily arranged. Autopsies will be obtained in a large proportion of cases when they are desired by the members of the staff for their own benefit, and for the benefit of the public. A few minor considerations are worthy of emphasis.

1. The examination should be staged in a decorous manner. Death is always a solemn event, and for many persons it is associated with extreme horror and despair. Hence, every dead body should be housed and handled as reverently and as carefully as circumstances will permit. The morgue should not be a coal bin or a storage room; the attendants should carry the body carefully to it; the witnesses of a post-mortem examination should be orderly and decorous, and those who are making the examination should quietly and systematically expose the various sites of disease without undue distribution of organs or other offensive materials. At the close a careful restoration of the body should be assured and the utmost care exercised to enable the embalmer to accomplish his task satisfactorily.

2. A full and frank discussion of the entire course of the case and the cause of death should be held with the relatives. Details of the history may thus be more completely established, and matters of importance from the standpoint of heredity may receive considerable light. Nothing more valuable than these conferences can be proposed, if it is really desired that the public shall be reassured as to the limitations as well as the competence of their physicians.

3. In the staff conferences at which the cases are thoroughly reviewed, the important gross specimens, neatly and unoffensively exhibited, together with the microscopic sections, should all be available. Free discussion should be promoted. Individual responsibility should not be emphasized, but the case discussed in such a manner, and failures of diagnosis so freely admitted, that only the important lessons will stand out and individual sentiment will be replaced by the desire that the whole staff may benefit to the utmost. Only with such a spirit can physicians fulfill their obligations to their colleagues and to humanity, and only with the promulgation of such ideals can it be truly promised the public that its dead shall not have died in vain.

FOOD PROBLEMS IN STATE HOSPITALS*

By A. L. BOWEN, Former Superintendent of Charities, Illinois State Departmenf of Public Welfare, Springfield, Ill.

IS THERE a state hospital that is satisfied with the food it serves, either to its patients or its employees? It is quite improbable that any will contend that its kitchen and dining room problems are even near solution.

No factor in the care of mental patients excites so much agitation and rebellion and gives the conscientious management so much concern as poor meals. Nothing could exert a better influence toward peace and contentment than well-cooked and served meals.

Employees and patients alike complain of their food. Friends and relatives of patients take up their cudgels and protest to superintendent and frequently to the governor himself that hospital meals are not what they should be. In my experience, I believe food was more often the subject of discontent and investigation than any other two or three subjects taken together.

Many efforts have been made and are being made to improve kitchen and dining room service in these institutions. However, this subject must receive much more attention and study before the dietary of the average state hospital will be what humane care and health considerations demand.

The difficulties are not mechanical, except perhaps the procuring of money with which to purchase what the market affords in the way of equipment. There are many examples of good kitchen and dining room planning and construction. Where these service buildings should be located depends upon local conditions. A hospital with funds for new service building and equipment is without excuse for blundering; for practically all questions in this particular realm have been answered by experience at new institutions or at the old ones that have rebuilt their kitchens, dining rooms and bakeries. Every superintendent who is not informed as to planning and equipment may learn much by expending a few dollars in travel and study.

A state hospital has the same opportunity as a good hotel to outfit its dining rooms and kitchens with modern, durable equipment. Moreover, the problems of cooking and serving in the state hospital are frequently not in themselves much more difficult than those in large hotels or many restaurants.

But the state hospital is handicapped in personnel. A legislature that may be liberal in allowances for equipment and buildings may refuse the funds with which to employ men and women who know how to use them to the best advantage. Granted that there are liberal allowances, even then it is difficult to get those who know how to use the new equipment to the best advantage and to cook in large quantities. If you impose the additional requirement that the employee study variety and the wants of the conglomerate mass to be served, you create a standard in kitchen personnel almost beyond reach at this time.

Graduates of recognized schools of home economics have not found state hospital service attractive.

More than once I tried to interest the seniors of such schools in the Illinois state hospitals, but with no success. They had in view more congenial employment with less responsibility and a remuneration very often much higher than the state hospital would pay. Fifteen hundred or three thousand mental patients and three hundred or six hundred employees to be fed three times a day, often from poorly planned and inadequately equipped kitchens, seemed to frighten them away.

Inefficient Cooks Prevail

As for chefs, the state will not compete with hotels or even with middle-class restaurants. The result is that the state hospital must depend upon "cooks," recruited from those who have learned somewhere how to mix certain foods in large caldrons and to dish them out in scoops. To give food an appetizing flavor, to vary the forms in which staples may be served or to produce variety is beyond their knowledge and education. To get the day's job done is their first objective. The noon meal, cooked early in the morning, taken up two hours before it is to be eaten, placed on the tables from thirty to sixty minutes before the patients are admitted to the dining rooms is a common procedure in many state hospitals. Raw foods of the very best brands are thus spoiled and rendered unpalatable, if not offensive.

A woman told me once that she had not eaten an egg since her admission several years before. When I made inquiry, I discovered that the state's buyers regarded eggs as too expensive and the "cooks" said it would be impossible to serve them to such large numbers. A little study disclosed that eggs in season were no more expensive than other foods and that the "cooks" who wanted to, could find ways to prepare and serve them. On

*This is the first of two articles on the subject of state hospital food problems, prepared for The Modern Hospital, by Mr. Bowen.

my rounds of state hospitals I received an almost daily request that milk be served. Coffee and tea, I was told, never contained sugar. The reply from the kitchen was that sugar and milk were placed in the urns, but a more thorough investigation showed that very little of either found its way into the coffee or tea and that it was indeed seldom that patients were given milk to drink.

The Milk Problem

Dairy herds were seldom sufficient to supply all the milk institutions needed or could use. Resort was had to neighboring dairies and purchases were made on minimum standards. Constant vigilance was necessary to see that even these standards were respected in the deliveries.

The state exercised the strictest vigilance over the herds at its state institutions and condemned for tuberculosis with a liberality that sometimes was inexplicable. The smaller the institution's herd, the more milk must be bought from the local dairies and these were seldom inspected for disease.

Unless the rules of the institution are very strict, the cream not removed for butter is kept for the tables of the superintendent and officers, while the skim milk goes to the employees and what is left is delivered to the patients, generally in the form of cooked foods. Justice to the patients demands that they be served whole milk, at least once a day, and that no cream to be extracted for butter. Butter should be bought and the milk saved for consumption in its original form.

Institution gardens grow vast quantities of fresh vegetables. But how often are they delivered at the preparing room too late in the morning for the noon meal that day. Since not many institutions break their rigid rules and serve them at evening, they stand for twenty-four hours thereby losing all their freshness and flavor. The same gardeners, catering to city trade, would deliver their produce early in the day and the marketeer would take proper care of it so long as he exposed it for sale.

Complaints that the bill of fare undergoes little change day by day, is met by the reports of what the kitchen has served each day in the year. In the service with which I was connected, we required that each institution in the department forward to our office a copy of the menu of each meal each day. Blanks were prepared for this purpose. The amount of each food issued was also to be set down and the caloric values estimated from recognized tables.

How often and how easily these could be misleading soon became evident. Weighing was carelessly done; only now and then was there a cook or so-called dietitian who knew how to compute calories. The reports did not enlighten us on the quality of meat served.

As an example I took a menu that reported one day the serving of pork chops at the noon meal. A quiet inquiry revealed that a few hundred of the male patients had pork chops while the rest of the patients, some two thousand, enjoyed the usual stew.

Meat included the bones. The choice cuts were issued to the superintendent, the next best to the officers and physicians, the next to the ward employees; what was left went to the patients' kitchens. These are old hospital practices which are slowly going out of style but still are entirely too prevalent.

The food problem in state hospitals will be solved when food departments employ men and women of the qualifications required in good hotels and restaurants. If the head of the dietary possessed the requisite ability, the institution could easily save the difference between his salary and the wages of the average "head cook." Among the qualifications to be demanded is that required in the civil restaurant; namely, an interest that will be centered in the preparation of something new that has a character of its own.

The chef, if he may be called such, of a state hospital, should also possess a sympathy for the helpless and unfortunate, to whom he caters; a realization that in their food the patients may find

(*Continued on page 523*)

The Crux of the Problem

. . . A legislature that may be liberal in allowances for equipment and buildings may refuse the funds with which to employ men and women who know how to use them to the best advantage. . . .

Graduates of recognized schools of home economics have not found state hospital service attractive. . . . They have in view more congenial employment with less responsibility and a remuneration very often much higher than the state hospital would pay.

Inasmuch as the state is not apt to pay the salaries that will attract the talent the job really requires, improvement may be made by a training course for those who are engaged in this work.

THE SOCIAL SERVICE DEPARTMENT OF THE MINNEAPOLIS GENERAL HOSPITAL

By WALTER E. LIST, M.D., Superintendent and GLADYS R. K. LUSH, Director, Social Service, Minneapolis General Hospital, Minneapolis, Minn.

HOSPITAL social service, an administrative medical division of the hospital, represents the soul of the institution—through which it registers the innermost sensations of its human acts.

The Minneapolis General Hospital, a municipal institution, admits illness and accident cases of all kinds, although it does not keep for permanent treatment mental or tuberculous patients.

The following is a resumé of the in-patient and out-patient activities for the year 1924:

Patients admitted during the year	8,893
Births (within the hospital)	1,247
Patients discharged during the year	9,327
Patients died during the year	900
Treated in receiving ward—not admitted	12,991
Treated in out-patient department	63,887

The socal service department consists of the director, six social service investigators, a handicraft worker and two stenographers. The work is divided among the workers according to classification, and, with a few exceptions, the same worker handles a case throughout the period of its contact with the hospital. She interviews the case in the dispensary, follows it after admission into the hospital, and after discharge does the necessary follow-up work.

Three Special Investigators

One investigator handles the medical cases, also orthopedic and surgical cases in the out-patient department only, but not in the hospital. The reason for this is that the medical service is too heavy for the investigator to do all that is required with both the orthopedic and surgical cases. She can, however, handle these cases in the out-patient department. Another investigator devotes her time to maternity and abortion cases. As the hospital has a prenatal clinic with nurses who make home visits, the social investigator does not have to be stationed in the out-patient department. Another worker specializes in children's work. For this service it is considered desirable to engage a graduate nurse, and she, having the required technique, is able to visit the contagious wards to make financial investigations and to handle the more urgent problems that she finds there. Another investigator is assigned to the venereal cases, and still another one to mental cases. The duties of the sixth investigator are varied. She does the social work that is necessary for surgical cases while they are in the hospital, investigates the applications of chronic cases, arranges transfers to other public institutions—such as military hospitals, and hospitals and sanatoriums for tuberculous patients. Each investigator should be able to dictate her reports in person or by dictaphone, the same to be transcribed by a stenographer. This should enable her to make more complete reports and, in addition, give her more time for other work.

Not Responsible for Financial Investigations

The social service department is not responsible for financial investigations which are made when patients apply for treatment in the out-patient department. A financial investigator, separate from the social service department, interviews every new applicant for treatment. This financial investigator intimately cooperates, and refers to the social service department patients who, because they are non-residents, are not entitled to care, but whose need is too great to be met by nothing but a straight refusal. The social service department then advises admission or arranges for treatment elsewhere.

Each patient admitted to a ward is interviewed by a social investigator. Facts regarding residence are definitely ascertained and a financial investigation is made enabling the director to decide regarding a hospital bill. This interview establishes contact, and furnishes the department with the main social facts, thereby revealing some of the more urgent problems. After this routine investigation is made, each case is immediately registered with the Confidential Exchange, which facilitates cooperation between the hospital and other social agencies: the hospital is notified which agencies have known the case and these agencies are notified of the hospital contact.

In the financial investigation an agreement is made with the patient regarding his bill and charges are made on a sliding scale, from fifty cents to the cost per diem of three dollars and twenty-five cents, based upon the following factors:

Number in the family and earning capacity of each.

Rent paid.

Property—mortgages, etc.

Outstanding bills.

Length of illness and prognosis.

There is no question but that each individual case must be settled on its own merits and that no regulation will apply to all cases. It is our opinion that patients, whenever possible, should pay, as this encourages thrift and builds up a conscience that service, no matter from what community agency, costs money. Bills are rendered monthly, and during the year 1924 nearly fourteen thousand dollars was collected. We are in favor of making graded charges in a community hospital and we make every attempt not to admit patients who can afford the services of a private physician in the home or the services of a private physician in a private hospital. At times it requires the wisdom of Solomon to make this decision.

The department frequently arranges for the admission of patients. Cases are reported in which not only the illness, but also the living conditions have to be taken into account. It is the duty of the social investigator to have such knowledge of the facts as will enable her to know whether hospitalization is advisable. Then there is the patient (such as the mother with young children) who needs hospitalization, but whose home responsibilities are so pressing that she feels she must refuse the care she needs. It is then the duty of the social investigator to make the patient realize the urgency of her need and to help her make arrangements which will make it possible for her to enter the hospital.

The situation to which reference has been made shows how difficult it may be for a patient to follow the doctor's advice. This difficulty may also be felt when surgical appliances are required. In some instances it is sufficient for the social service department to enable the patient to obtain discount; in cases where financial help is being given by a welfare agency, that agency will as a rule, when requested by the department, give the appliance required; but in some cases the social service department has to recommend payment from hospital funds.

At the request of the staff physician, and such requests are frequent from the mental service, the social service department secures complete social histories. This necessitates interviewing persons connected with the patient, and reading the records of other agencies. When the staff physicians on the mental service have made their recommendations, it is the duty of the investigator on the case to help put the plan into effect. Sometimes it is considered advisable for the patient to continue doing regular work under proper supervision. The investigator tries to make arrangements for such conditions. If it seems necessary for the patient to be sent to a mental hospital the worker tries to persuade the relatives to follow the advice given, and, if necessary, explains to them the necessary procedure.

FINANCIAL FACTS

Income	Insurance	Dependents
Rent	Mortgage	Debts

Charges Recommended

SOCIAL HISTORY

SERVICES RENDERED

Date	

Back of card.

Cooperate with Child Welfare Board

The maternity investigator attempts to verify marriages which seem doubtful; and, when no marriage has taken place, the facts of the case are ascertained, and, if possible, the department gets in touch with the father of the baby. No attempt is made to urge marriage, but when both man and woman are willing, the social service department helps with the arrangements, and quite a number of marriages take place in the hospital. If marriage is not feasible, a full report of the case is made to the child welfare board, and that agency cooperates with the social service department in planning for the welfare of mother and child. They are frequently placed in maternity homes.

Unmarried mothers are not the only patients for whom provision has to be made. It is often necessary to provide convalescent care for women and girls. Arrangements are made for them to go to a club house or convalescent home, which has a certain number of free beds. The social service department realizes to the full the problem presented by the homeless men, who are found in such appalling numbers in the Middle West. Upon leaving the hospital these men are frequently without positions and without money. The social investigator tries to ascertain the circumstances of these patients, and then directs them to the free lodging houses, provided by the city and by the community fund. There are, however, men and women who because of age or some other disability require permanent care. The social serv-

ice department does what is possible to make relatives assume their responsibility. When there is no one upon whom the department can call, application is made to the home for the aged and infirm.

Some patients, though not totally incapacitated, are nevertheless too seriously handicapped to be able unaided to cope with industrial conditions. Such patients are referred to the state department of re-education, which tries to find work suitable for the patient and, in some instances, arrange for him to have special training. One patient, a heart case, who was taught to do shoe repairing is now supporting himself in that work.

Responsibility in Follow-up Work

The work of the department in planning for patients leaving the hospital is greatly facilitated by the fact that patients sign out of the hospital by way of the department. To the completed medical chart are attached two slips of paper; one of these states the diagnosis and the doctor's recommendations for further care; and the other tells the patient when to report to the out-patient department for further treatment, and which clinic he should attend. The investigator who sees the patient at the time of discharge explains these directions to him.

The social service department is responsible for seeing that cases are duly registered with other health agencies; tuberculosis patients are reported to the city health department and venereal patients are reported to the state board of health.

So far as venereal patients are concerned the responsibility of the department does not end with this report. The social investigator handling this branch of the work tries to have the immediate relatives of the patient examined. She also sends letters and pays visits to delinquent patients urging them to take treatments, and only when these measures have failed does she call in the aid of the state worker.

Besides venereal cases, other patients are followed into their homes. These are usually patients who have been on the mental service or the pediatric service; however, an attempt is made to follow the more serious medical cases. Maternity cases, also, are reminded by letter when it is time for them to report to the obstetrical clinic.

If the patient or his family are being visited by another agency, such as the family welfare as-

Form 290 5M 1-25 41827 S. S. D. No. Reg. No.

MINNEAPOLIS GENERAL HOSPITAL DEPT. OF SOCIAL SERVICE

Surname | First Name

Admitting Address | Discharging Address

M S W D | White Black | Occupation | Employer

Birthplace | Res. in City | Res. in U. S. | Former Res. | Nationality | Religion

Diagnosis on Admission | Former Admission

Station | A B | Med. Surg. Obst. Gyn. | Con. Hopewell Chil. Orth. | N. M. T. N. E. T. A. Skin U. G. | Quar. | Condition: Fair Serious Poor Critical | Drinking: Unconscious Intoxicating Moribund | Admitting Physicians

Brought by | From | Date | Ambulance Driver

Remarks

Discharging Diagnosis | Condition | Date

Relatives	Address	Kin	Age	Occupation	Wage

Interested Individuals or Agencies

Face of card.

sociation, a report containing diagnosis, prognosis, and recommendations is sent to this agency, and its help is enlisted in the necessary follow-up care.

Surgical cases, and other cases needing some nursing attention after leaving, are referred to the visiting nurse association, which gives invaluable cooperation.

It would be an ideal arrangement if the visiting nurse association, which is a non-official body in the community, could be made a department of the community hospital in every district. Through this agency ideal follow-up work could be done, thereby preventing duplication of effort and a continuation of the hospital contact. Without this means it seems only logical that the follow-up work from a hospital social service department should be reduced to a minimum. Preferably cases could be referred upon discharge from the hospital to other social service agencies in the community in order to save time, prevent duplication of effort, and in protracted follow-up cases secure closer supervision. If the visiting nurse association in the community becomes a part of the general hospital system, this would present an ideal arrangement for community service both for the follow-up of hospital patients and for nursing service to the sick poor in the various districts. Under these conditions the hospital would become the ideal public health center of the community.

The question arises as to whether or not the visiting nurse association should devote its time to nursing service and to hospital social service, but it is apparent that a combination of these efforts can be made economically and efficiently for the benefit of the community.

FOOD PROBLEMS IN STATE HOSPITALS

(*Continued from page 519*)

their greatest pleasure and satisfaction.

Inasmuch as the state is not apt to pay the salaries that will attract the talent the job really requires, improvement may be made by a training course for those who are engaged in this work. The state might afford to pay one "top notcher" to organize a training school and demonstration for cooks, at which the more promising from the various state hospital kitchens in the state might be taught practical methods. I believe that the central training school idea contains merit, but its success depends very largely upon the teaching ability of the person employed.

Along with this training should be a policy of gradual elevation of wage scales. As a general rule, it has seemed to me that women are better adapted to head the food division of a state hospital, as they generally show an interest and sympathy that men infrequently possess.

VETERANS' BUREAU ADDS FOUR FIELD MEN

In order to carry out the work of regional and hospital standardization of clinical and administrative service in the field, General Hines, director, U. S. Veterans' Bureau, has just assigned four medical supervisors to a tour of field duty with stations at New York, N. Y., New Orleans, La., Chicago, Ill., and San Francisco, Calif.

To facilitate the handling of medical problems, it is the plan of the director to alternate field and central office service for staff physicians so that they may become thoroughly familiar with all phases of medical administration both in the field and the central office and also in order that the medical service may be completely standardized and uniform throughout. This plan was strongly endorsed at the last meeting of the medical council of the bureau in February.

Dr. Winthrop Adams will take station in New York and his territory will cover the states of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, West Virginia and District of Columbia. Dr. E. P. Odendhall goes to New Orleans and his territory will cover the states of North and South Carolina, Tenn., Georgia, Florida, Alabama, Mississippi, Louisiana, Arkansas, Oklahoma, and Texas. Dr. Ord Everman is assigned to Chicago to serve the states of Ohio, Indiana, Kentucky, Illinois, Michigan, Wisconsin, Iowa, Missouri, Kansas, Nebraska, Minnesota, and North and South Dakota. Dr. George C. Skinner, until recently acting manager of the Dist. of Columbia regional office of the bureau, will be stationed in San Francisco, his territory comprising the states of Montana, Wyoming, Colorado, New Mexico, Utah, Arizona, Nevada, California, Oregon, Idaho and Washington.

PREPARING THE PROFESSION FOR HEALTH EXAMINATIONS

The growing interest in routine medical examinations of well persons was touched upon by Dr. J. C. Vail, in a presidential address recently delivered before the section of epidemiology of the British Royal Society. He stated that the whole medical curriculum was now being revised with the definite object of permeating the entire period of study by the principle of prevention. Every subject from applied physics, chemistry, biology, anatomy, up to the clinical courses, is to be taught with a view to the maintenance of health, as well as the cure of disease. He made the interesting observation that teachers of medicine desiring to develop a new orientation may find a better field for instruction in the out-patient department of the hospital than in its wards.

He is a good man, who can receive a gift well. We are either glad or sorry at a gift, and both are unbecoming. Some violence, I think, is done, some degradation borne, when I rejoice or grieve at a gift. I am sorry when my independence is invaded, or when a gift comes from such as do not know my spirit, and so the act is not supported; and if the gift pleases me overmuch, then I should be ashamed that the donor should read my heart, and see that I love his commodity and not him. The gift, to be true, must be the flowing of the giver unto me, correspondent to my flowing unto him.—*Emerson.*

ORGANIZING AN EFFICIENT CASE RECORD DEPARTMENT*

By JOHN WESLEY LONG, M.D., Surgeon-in-Chief, Wesley Long Hospital, Greensboro, N. C.

I AM asked to discuss with you the organization of an efficient case record department in a hospital. The title of my subject presupposes that hospitals should have such a department. As a matter of fact, in this day of enlightenment it is generally recognized by both profession and laity that records are the sine qua non of a modern hospital. Their importance admits of no debate. Their necessity is absolute. Without records the work of a hospital is like a rope of sand; it breaks of its own weight, having no cohesive force, no tensile strength, no continuity.

When a man who works in a hospital that does not keep records has been gathered to his fathers, his life work, however excellent it may have been, becomes only a memory. The rich inheritance of his experience which he, and his hospital, should have left to the profession takes wings and flies away. For a physician to spend much of his time in the indulgence of indolent pleasures, rather than in the labor of recording his activities and the invaluable lessons of wisdom to be drawn therefrom, is to trade the birthright that belongs to posterity for a mess of pottage.

Case records are not only of value for immediate use but they are the final court of appeal for the historian. Had Crawford W. Long, of Jefferson, Georgia, put on public record at the time of its performance his first case of ether anesthesia in 1842, the first that ever took place in the history of the world, there would never have been any controversy regarding the claims of the disgruntled and heartbroken dentist from Massachusetts to whom congress awarded the credit for the discovery that ether was an anesthetic.

Hanging in a conspicuous place in a certain hospital in a southern city is a legend which reads "A man shall be known by his records." He who wrote that sign put his finger upon a vital spot of hospital efficiency.

Many hospitals hesitate to establish a case record department because of the extra cost. The superintendent of a one-hundred bed hospital recently said to me deploringly, "Why, we appropriated two thousand dollars for our record department last year." My reply was "My dear doctor, you are getting off cheap, I spend more than that every year in the case record department of a smaller institution than yours." The hospital that, on the score of economy, does not maintain an efficient case record department is possibly penny wise, but most assuredly it is pound foolish. I know of no department of a hospital that yields a richer income in reputation, in satisfaction, in the development of scientific work and, ultimately, in the increase of patronage, than does an up-to-date case record department.

The greatest difficulty involved in this question is getting some one to write the records; and the smaller the hospital the bigger is the problem. This is a far more valid excuse than the cost of the department. It is easy enough to employ a stenographer who will write down what is dictated to her, but the real historian must go far beyond this and follow the case all the way through from alpha to omega. The scarcity of historians necessitates the professional staff doing a large part of the history work.

Colleges Should Teach Record Writing

I believe it would help to solve this vexatious question if our medical schools would teach their students the art of writing case records; indeed, some of the colleges are already doing this. Hospitals themselves might profitably give lectures

A Heritage of Posterity

WHEN a man who works in a hospital in which records are not kept has been gathered to his fathers, his life work, however excellent it may have been, becomes only a memory. The rich inheritance of his experience which he, and his hospital, should have left to the profession takes wings and flies away. For a physician to spend much of his time in the indulgence of indolent pleasures, rather than in the labor of recording his activities and the invaluable lessons of wisdom to be drawn therefrom, is to trade the birthright that belongs to posterity for a mess of pottage.

*Address delivered before the hospital conference of the American College of Surgeons, Chicago, October, 1923.

and demonstrations to their interns and clerical help.

A hospital is supposed, in a sense, to be like the doctor himself, or like a lawyer who is possessed of much knowledge, to whom those who have the right to ask may go for information. But if a hospital does not have a case record department to whom shall one go for the desired information?

Last winter I was on a lecture itinerary with a party in the interest of the American College of Surgeons. One of the cities in which we held a meeting was Witchita, Kansas. The National Cash Register Company has a business house there and in their show window they display a sign which reads "A house without records is like a clock without hands, still running but giving out no information." In this respect some of our hospitals may also be aptly compared to our "mansions in the skies" which we are told "were made without hands."

There are two points of emphasis in my subject. The first is organization. Those who arranged this program chose wisely when they specified the "organization" of an efficient case record department. Without organization nothing worth while is ever accomplished; professional life, social activities, war politics, welfare work or individual enterprises; all depend, without exception, upon organization for their success. True, every great enterprise is born in the brain of some idealist; but unless he can reduce his ideas to some practical form that will invite the confidence and cooperation of his fellow man his dreams will never materialize and he will be put down as a crank. Therefore any plan to produce beneficent results must be organized, so that every good. Organization, therefore may be called the machinery that produces the goods.

Record Keeping an Innovation

Organization is especially necessary in establishing an efficient case record department for several reasons, one of them being that to most of us the keeping of records, certainly in anything like a systematic manner, is a new departure. We built and ran hospitals in the old slipshod way for such a long while, without ever having sensed the necessity of keeping records, that we came to regard history taking as a work of supererogation. True, many hospitals did keep records, but generally speaking this was not done. I once worked in a hospital that made it a practice to burn all records as soon as the patient was dismissed or died.

Hence when the word was passed down the line that hospitals must keep records or be weighed in the balance and found wanting it was regarded as an innovation and most truly it was. This thing of having to write down everything that was done produced about as much mental perturbation in certain quarters as did the handwriting upon the wall in old Belshazzar's court. Some hospitals have not yet fully recovered their equilibrium. However, even the most unorthodox are beginning to sit up and take notice.

You know it is not an easy matter to change established customs of any kind anywhere. But in the scientific world the watchword is "progress;" we must go forward. "Where the vanguard marches today the rearguard shall rest tomorrow."

Team Work Essential

Now, to organize a case record department efficiently it is necessary in many instances to convert the entire staff. They must be shown that it is to their interest to conform to the standard set for hospitals. We must sell them the proposition. Hospitals, like all human institutions, have a personal equation, and should be approached in the spirit of helpfulness and not in a dictatorial manner. This requires both diplomacy and perseverance.

By the staff I mean not only the professional men but the management as well, whether it be the physicians themselves, a board of trustees, some religious order, the city council, or whatever body controls the institution. Also it includes every attaché of the hospital—physicians, interns, secretaries, technicians, nurses, domestics and even the undertaker, since he can be of so much help in the matter of autopsies. I will go still further and say that we must get our patients committed to the value of case records. You know that sometimes an obstreperous patient resents giving any information whatever about himself. In automobile casualties, especially if they be the result of a "moonshine ride," people often refuse to give even their names.

In other words, every one connected with the hospital must be in thorough accord with the new order of things. One balky horse in a team will stop the wagon. It is the pull-together spirit that gives the maximum degree of efficiency to an organization, and to every one associated with it. Kipling puts it forcefully in "The Law of the Jungle" when he says:

"For the strength of the pack is the wolf,
And the strength of the wolf is the pack."

House Divided Cannot Stand

I stood a few years ago upon the ruins of a home that had been demolished and the family

scattered far and near, some of them to the cemetery. The only living son of that family stood by my side. As we gazed upon the physical wreckage about us he said, as if talking to himself, "A house divided against itself cannot stand." And then I recalled, for I had known the family in my youth, that the father and mother of that home had not spoken to each other for thirty years. The truism uttered by that scion of a once prosperous but now destroyed home is as axiomatic of the professional life of the hospital of today as it was of the family life when it was written two thousand years ago.

Just here comes in the great value of regular staff meetings where the weak places of an institution, as well as the strong points, are brought out in bold relief and the proper remedies applied.

Case Records Constitute a Department

The second point of emphasis is on the word department. Department signifies a major division, and as such is equal in importance with any other part of the institution. Surely the modern conception of a hospital attaches as much significance to the case record department as it does to the culinary department, or the financial department or indeed the operating department; each constitutes an essential part of the whole.

The mistake that we made in former times was to leave the recording of cases to the pleasure and the convenience of the surgeon; and usually he never found it convenient and certainly it was never any pleasure to him to perform such an onerous task. Even the diagnosis he often left sub judice rather than take the trouble to write down his opinion. Under the old regime we looked to the individual and not to the organization. Happily in the language of a popular cartoon "Them days is gone forever."

Last year I attended a pure food exhibit in this city. One of the big packers had a booth in which was shown the slaughtered steer and sixty-seven of its by-products. While many by-products, either good or bad, emanate from the work of a hospital, the case record department is not one of them. If it does not represent the hind quarters of the steer it certainly stands for the backbone, the spare ribs, the heart, the lungs and the liver of the noble animal. Therefore in the organization of a case record department I would insist that it rank equal with any other division of the institution.

System Must Be Simple and Sound

In order that a case record department shall function in the most efficient manner it must be organized along lines that are sound, simple, sensible and scientific.

(1) The scheme should contemplate that the records be truthful, without evasion, omission or prevarication; thus they will be sound.

(2) The system must not be complicated, but so simple that the wayfaring man can read as he runs. The various reports from the laboratories, anesthetist, surgeon and every one connected with the case, should so harmonize and dovetail into each other that the whole is easily comprehended. This is not possible unless the system adopted be understandable and workable.

(3) The formulated plans should be the embodiment of common sense; not full of fads, frills, air pockets, cross currents or enigmas. In other words, they should be arranged along practical lines so that every one familiar with case records may trace the history of the patient from the entrance card, through the physical and laboratory findings, operating room, post operative care, to the ultimate outcome, whether the patient be sent home or autopsied.

(4) Furthermore, the system should contain the essential elements of an up-to-date medical synopsis so that the records may be adjusted scientifically.

Thus far we have discussed only the principles of the case record department and not the details. There are certain details that must be worked out according to the peculiar work and environment of each individual hospital. The exact method one institution employs might not be the best for another, but the essential elements should be the same in every instance.

Most of the hospitals with which I am familiar use some form of loose leaf or card system. When the case is completed the various leaves, blanks or cards are assembled and filed in an envelope or bound in book form. Certain hospitals prefer envelopes; at the Wesley Long Hospital we bind our histories in volumes as a matter of both convenience and economy.

Whatever system of records is adopted there should by all means be an adequate index. The index is the milk in the cocoanut of a case record department. The system of indices that we employ is very simple and satisfactory. We use cards 5x3 inches. The first index in importance is arranged alphabetically giving the patient's name, address, volume and page. The next index divides all cases into well recognized groups, such as hernias, cancers of the breast, hysterectomies, etc. This index also gives the name, volume and page. In addition each volume carries its own index.

In the Wesley Long Hospital I can send a nurse

to the library of the case record department and within a minute or so she will find the history of any patient that we have operated upon in the last eighteen years. This would be impossible but for the practical indices which we employ. I cannot stress the value of indices too strongly.

Another point often overlooked is the filing and location of case records. So often they are stowed away in a dark closet or piled up in the basement or some other inaccessible place. The result is obviously very unsatisfactory. Case records should be where they can be reached easily and quickly. Our case records are kept in my consultation office which, by the way, is in the hospital.

Accessibility often saves one from embarrassment. Recently a man and his wife from another town consulted me. I asked them what I could do for them, the lady said "we came to see you about this pain in my side." I asked how long she had had the pain. She replied "Ever since you operated on me five years ago." Whereupon I consulted my alphabetical index, found the volume containing her history and turned to the page. I read to them from her record which stated "I have a pain in the right side of my abdomen and have had for twelve years." "Do you remember telling me that?" I asked. "No," she said, "I only remember having the pain from the time you operated on me." In other words, she was making me responsible for a pain that she had had for twelve years before I ever saw her. My record of her case refreshed her memory wonderfully.

Hospitals that have efficient case record departments soon come to regard them as the public does good roads; after trying them once, they are never willing to give them up. To get the most out of case records we must go after the proposition in such a manner as to "bring home the bacon," as we say down south.

In conclusion I want to add that so far we have been discussing this important question from a material standpoint, in fact we might say from a purely selfish aspect. That is all right, but you will agree with me that the spiritual side of one's work is the highest. We have been looking at hospital standardization in the light of our convenience, the emoluments to be derived therefrom, the fortifying of our prestige and the development of cold science. But what about the patient? Do our plans contemplate nothing beyond getting him into the hospital and curing him of his physical ills? Shall we not follow him always with that interest that stamps us as our brother's keeper?

The question that every physician and every attaché of every hospital should ask themselves every day is "What is the best thing that I can do for my patient?" And whether or not we receive immediate compensation for our services, we have the assurance from lips Divine, that "Inasmuch as ye have done it unto one of the least of these, my brethren, ye have done it unto me."

LOUISVILLE ORGANIZES HEALTH COUNCIL

Plans have recently been completed for the organization of the Health Council of Louisville and Jefferson County, Kentucky, which is designed to coordinate public and private health and hospital activities in the district. Any public or private agency conducting services for health or caring for the sick is eligible for membership and will become a member if approved by the council. The plan is similar to others being successfully operated in Cincinnati, Cleveland and San Francisco.

The council, which represents each organization and institution dealing with public health, has as an objective, the formation of a forum for the discussion of health and sickness problems, the improvement of present standards of service and the establishment of additional health facilities.

At a meeting held March 18, 1925, a constitution and by-laws were adopted and officers were named to serve through 1925. Miss Anna C. Phillips, New York, N. Y., was named executive secretary, and Alex G. Barret was elected chairman; Dr. Irvin Abell, first vice-chairman; and Joseph D. Burge, Jr.. second vice-chairman.

Each member organization will have one or two representatives who will be divided into several standing committees. A coordinating committee, composed of one member from each standing committee and fifteen citizens, not members of any organization, will constitute the ruling body.

The progress of the organization of the council will give the delegates to the American Hospital Association meeting to be held in Louisville October 19-23, an opportunity to see a city in the early stages of community-wide health planning.

WORLD WAR MEDICAL OFFICERS BANQUET AT A. M. A. CONVENTION

A feature of the annual meeting of the American Medical Association at Atlantic City, N. J., was the reunion of the medical men who served in the army and navy during the World War, May 27 at 7 p. m. at the Ritz-Carlton Hotel. The chief surgeon of the A. E. F. was there, and the president of the Association of Military Surgeons, Surgeon General Hugh S. Cumming, and other officers of the association under whose auspices the meeting was held. An effort was made to group together those who served in the same organizations.

INSTITUTIONAL MANAGEMENT COURSE

A course in hospital and institutional management will be conducted this summer at Temple University, Philadelphia, Pa., under the direction of Dr. J. Norman Coombs, school of medicine, Temple University, and Mr. C. S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, and will follow the general plans of those of previous years.

ESSENTIALS IN DIRECTING NEWSPAPER PUBLICITY

By I. W. BREWER, M.D., Superintendent, Pleasant Valley Sanatorium, Bath, N. Y.

AT INTERVALS for about forty years I have been conducting publicity campaigns through the medium of the press, and have usually been able to have what I have written printed. I have not confined my work to public health alone, although in recent years that has been the bulk of the work.

I once asked a gentleman, who had for many years conducted a publicity campaign, how he went about it. His reply was: "Know what you want to say; say it at a time when your audience is in a receptive mood; use language that they can understand, and be brief." I have followed as far as possible the formula given by my friend and I think it may be of some interest to others to have an analysis of the problem from that standpoint.

1. Know your subject. This means you must be so well informed that you will not be carried away by some glittering report, based upon faulty observation or scanty study of the subject. Not infrequently those who write for the press are unacquainted with scientific subjects and, as a result, try either to write something that will please or that will be sensational. While I was employed in a scientific library, a rather prominent writer called to get information upon a natural phenomeon which was of more than passing interest at that period. His education was not along scientific lines and his knowledge of physics was very meager. Upon going over our literature he selected a very sensational article from which he made copious extracts. Long afterwards he confessed that his article was crowded out by a brief paper of an obscure writer who apparently knew his subject.

Probably you recall the large amount of publicity which some time ago was given to a European who claimed to have a cure for tuberculosis. But his name soon passed into oblivion in spite of the newspaper. Another example was a recent publicity campaign in the interests of a Frenchman who would cure disease by a constant repetition of a very simple formula. Now both the remedy and the man have been lost sight of by the public. Had the newspapers known the subject of the prevention of tuberculosis, the first man would not have received more than a casual mention and the absurdity of the other man's claims would have been apparent immediately. On the other hand, the publicity campaign for the prevention of tuberculosis is still good copy for the newspapers.

Cardinal Principles of News

THE author gives the following essentials to hospital and public health people in conducting newspaper publicity: (1) know your subject; (2) say it at a time when your audience is in a receptive mood; (3) use language that people can readily understand; (4) be brief. These might be enumerated as the cardinal principles in presenting the news.

If hospital superintendents took cognizance of these principles there would be less complaint of the lack of appreciation of the daily press of vital scientific material contributed by the hospital and members of the medical profession. In most instances, if the stories were alive and not presented as antiquated and uninteresting facts, they would be accorded the place they rightly deserve in the daily paper.

2. Say it when your audience is in a receptive mood. This means when it is news. If you follow that plan the newspapers will be looking for what you have to say. An example may show better than many words what constitutes news. A paper recently carried an article on hydrophobia. The article was well written and contained much information but was tucked away on a remote corner of an inside page. Why? Because there were no cases of rabies in the vicinity at that time and very few people were interested. One wonders that the story was even given a place. However, had the writer kept his article until there was a case of rabies in the vicinity he could have begun his article with the information regarding the local cases, which would have interested the readers of the paper and, in closing, could have presented the preventive side of the question. To avail oneself of the time when an article becomes news means that the writer must know the subject so well that he can put it down on paper at a moment's notice.

Creating news is not always easy but can, nevertheless, often be done. We are all familiar with the arguments for pure milk and if they alone are to be rewritten it is doubtful if there will be space for them in the papers. But if the matter

can be presented from another angle it may become news. Recently a health officer was carrying on a campaign for pasteurization of milk. This was opposed by the dealers who did not have proper plants. It so happened that the meat inspector condemned a large number of hogs from a nearby creamery because they were tuberculous. Some time before this the state had made studies regarding the use of skimmed milk on the farm and had stated that its use, raw, was the principal cause of tuberculosis among hogs. These facts formed the basis of a news story which was widely published. It closed with the statement that if raw milk was not good enough for the farmer's hogs, why is it good enough for the farmer's baby?

Style Must be Simple

3. Use language that can be understood. To the physician, poliomyelitis has a very definite meaning but to the average reader it is just another hard word used by the doctors. The public, however, is very well aware of what infantile paralysis is. Encephalitis conveys no idea to the general public but people at once become interested if this disease is called sleeping sickness. Simple words and short sentences are easy to read and if well chosen mean as much as longer and more difficult words. The height of good writing is simplicity.

Brevity an Essential in Writing

4. Be brief. This is where most professional men fail. They know their subject and there is so much to it that they allow the language to flow until it covers pages; far more than any publication will give to the subject. I now have before me a very instructive article on a phase of public health which is "news" at present but it came to me from the waste basket. It is well written, full of valuable information much of which is new, but alas, it covers eighteen typewritten pages and two tables of more than a page each. No busy editor has time to read it and surely will not have space to print it. From it I shall abstract several short articles of three paragraphs each which will be printed in a number of papers.

In preparing regular articles issue them on fixed days. Send them to the paper with the date of release written plainly at the top of the page and, if possible, send them out at least one day before date of release. This is a great accommodation to the staff of the paper. Deal squarely with all the papers and play no favorites and never be angry if what you write is not printed. Sooner or later you will be approached by a reporter for an interview on a "scoop." If it is his scoop give him what you can on the subject but refrain from letting the other papers know about it. If it be a matter of great importance be prepared to furnish the other papers the information as soon as the original paper has appeared. Interviews which are requested should be treated as scoops. Follow these directions and you will stand well with the reporters and the staffs of the papers.

In giving out information use local data as far as possible. Do not be afraid to announce the appearance of any disease about which there is a positive diagnosis. Surmises, of course, may be kept quiet for a short time. Whatever you say, say it in a way that will not frighten the public but will make them think. When I was leaving a city where I had been health officer the local editor remarked that I had given the facts to the people without unduly alarming them. I had told them that small pox was present in the city and that there was a case of sleeping sickness. In fact we regularly reported every communicable disease. All of these articles were accompanied by detailed information regarding the prevention.

What is the value of publicity? It is hard to estimate the value of what one publishes, as one may have a valuation from very unexpected places. During an epidemic of scarlet fever we carried on rather an intensive campaign regarding the prevention of the disease. One Sunday I was called to a house where a child was sick with that disease. She was in a room as remote from the rest of the family as possible and all of the necessary precautions for preventing the spread of the disease were being taken. Upon inquiry being made as to who had instituted the measures, the mother produced a clipping from a local paper which she had saved for an emergency. Later when there was an epidemic of measles, as a result of our campaign, more than one-third of the cases were reported by the family. This was quite an improvement, for it had been rare for families to consent to being quarantined.

One of the best publicity campaigns I have ever seen is carried on by a small hospital. Almost every day there appears on the local page one or more paragraphs under "Home from the Hospital." Sooner or later the public will think a great deal about that hospital.

HOUSE REJECTS THERMOMETER BILL

The clinical thermometer bill to which reference was made in our April issue as having passed the Senate did not pass the House of Representatives so that it did not reach the President. However, Mr. George K. Burgess, director, U. S. Bureau of Standards, says that the bill will undoubtedly be reintroduced at the next session of Congress for serious consideration.

THE ISOLATION HOSPITAL OF THE CITY OF MEMPHIS

By JOSEPH PURVIS, Former Superintendent, Memphis General Hospital, Memphis, Tenn.

THE new Isolation Hospital for the City of Memphis, designed by Architects Jones and Furbringer, was erected on the grounds of the Memphis General Hospital where it is now fulfilling a long felt need. The building is planned to accommodate fifty patients at present and is so arranged that an addition can be built at a later date to accommodate 150 patients. As now planned, the center portion contains the service and administration offices, and the wings extending in each direction house the patients. To afford complete isolation the patients are placed in single rooms and only when several are convalescing from the same disease are they moved into the four-bed end wards. Some such routine as follows will be observed in the institution:

Isolation Hospital Routine

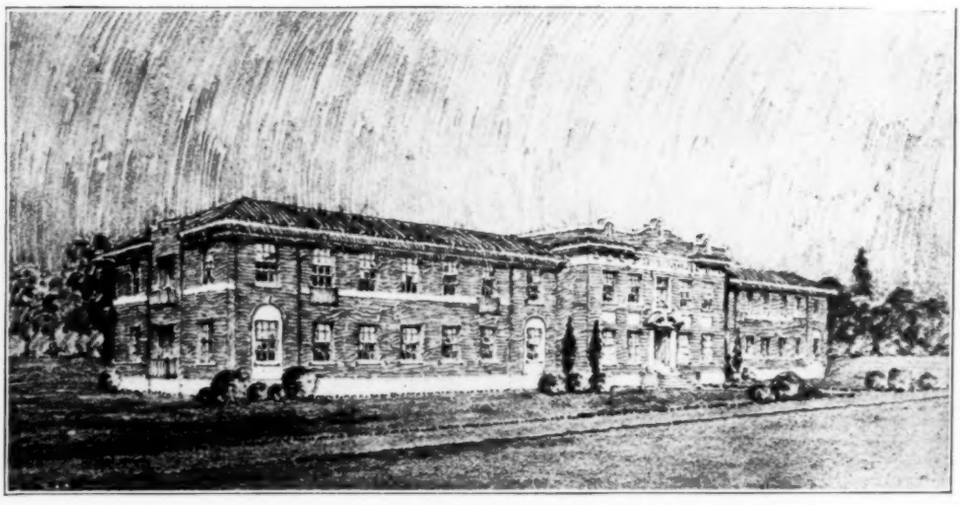
On entering, a patient is taken to the admitting room where a bath is given and a complete change of clothing is provided, the wearing apparel being disinfected and placed in a receptacle until such time as the patient has completely recovered.

In an institution of this kind the utmost care is necessary to govern against cross infection. For this reason, the greatest care and study were essential in planning the building, making the routine so simple and yet so positive that it is practically impossible for a nurse or doctor to carry infection from one patient to another. On the other hand, it must be possible for the relatives to be able to visit patients, for without this privilege the convalescence of the very young would be retarded and the very purpose of the hospital, to return the sick to health in as short a space of time as possible, would in a measure be defeated.

The nurse, when on duty, wears a special uniform which indicates she is confined for the time being to this particular building. Upon entering a patient's room, she dons an additional robe which completely covers her uniform. This robe is removed by her before again leaving the patient's room and is kept in that room. In each room is a lavatory with elbow contact, so the nurses can cleanse their hands without touching any of the apparatus. The doors, too, have special fittings which enable the nurse to open them without touching them with her hands.

This operation is repeated in visiting every patient and the same routine is observed by the doctors, for whom a special room has been provided where they may change their clothes for the hospital uniform, making it both safe for them and the various patients whom they visit.

Visitors, as a rule, are admitted only as far as the door of the patient's room where they can freely converse with the patient. In cases of extreme sickness, a visitor is allowed to enter the room. Then, however, the same precautions as observed by the nurse must be taken; a robe is provided and the visitor is both cautioned and watched to see that he does not touch the patient or come in contact with anything which the patient has touched. All dishes and trays on which the food is served to the patient are sterilized after use; even before they are cleaned after having been used, they are placed in a sterilizer which makes it safe for the help to handle them.



Perspective of the Isolation Hospital, Memphis.

The food is prepared in the diet kitchens, located on each floor and served to the patients by the nurse on duty. Portable tubs are used in which to bathe the patient, and the soiled linen is conveyed by a clothes chute from each floor to a receptacle in the basement, from which, after being sealed, it is carried with perfect safety to the disinfecting room in the main laundry building where it is washed without at any time coming

in contact with the clothes from the other patients of the general hospital.

The building was constructed of reinforced concrete and the exterior walls of brick and stone, the brick of a dark red color and the roof of green tile which gives both a pleasing color combination and an imposing exterior. As all interior partitions are of solid plaster, the building is as fireproof as it is possible to make it.

Also Build Power House and Laundry

A new power house and laundry will also be erected for which the plans and specifications are now being prepared by Jones & Furbringer. The heating plant, which will be located in the power house, will supply heat for all the buildings of the general hospital, including the general hospital, the nurses' home, children's hospital, laboratory building and the isolation hospital. This plant is so designed that it can be enlarged in the future as the needs of the institution make this necessary, and it will be located about half way between the present hospital and the new building. In connection with this power plant, will be a complete and modern laundry equipped with all modern machinery to handle the work of this institution.

Dr. Durrett, commissioner of health and Dr. Marcus Haase, chairman of the medical board of the general hospital, and Mr. Joseph Purvis, the former superintendent, have contributed in a large measure of their experience in the planning of this building.

WOULD REDUCE TAX ON CHARITABLE BEQUESTS

A bill was introduced into the last legislature of Pennsylvania providing for the reduction of the tax on charitable bequests from ten to two per cent. If this bill passes and becomes a law it will materially increase the sums which hospitals, religious, educational and charitable agencies and institutions finally get from a bequest.

Committees have been formed in both the eastern and western sections of the state to support and work for the bill. The Philadelphia committee consists of Judge Monaghan, chairman, representing Cardinal Dougherty; Hon. William Potter, Jefferson College and Hospital; Mr. Malcolm Lloyd, Jr., Pennsylvania Hospital; Mr. Arthur A. Fleischer, representing Jewish Institutions; Mr. Walter I. Cooper, Society for Organizing Charity; Mr. L. H. Fiske, Y. M. C. A.; Mr. Daniel D. Test, Pennsylvania Hospital; Mr. John M. Smith, executive secretary, Hospital Association of Pennsylvania; Mr. Newton E. Davis, executive secretary, Board of Hospital and Homes of the Methodist Episcopal Church; Dr. Frank C. English, secretary, American Protestant Hospital Association; Mr. Charles S. Pitcher, member of the national and state legislative committees of the American Protestant Hospital Association, and Mr. George R. Bedinger, Public Charities Association of Pennsylvania.

The Pittsburgh committee consists of Mr. Isaac W. Frank, representing Jewish interests; Mr. Zahnhiser, representing the Council of Churches; Mr. R. W. Harbison, representing the Y. M. C. A.; Mr. Frank Lanahan, representing Catholic interests, and Mr. Horace Forbes Baker, representing the Public Charities Association of Pennsylvania.

HAHNEMANN HOSPITAL HAS WINDOW DISPLAY IN COMMUNITY CHEST CAMPAIGN

An exhibit illustrating hospital work was recently displayed by Hahnemann Hospital, Scranton, Pa., for the community chest campaign carried on in that city. The window of one of the local stores was divided into two sections, one showing the quality of service rendered by the hospitals and the other suggesting the need for the funds to be raised.

In the first section were shown a nurse, a regular hospital bed, and two children's cribs, with the usual hospital ward furniture. In addition there were cards indicating the number of beds in the hospitals of the city, the total number of days' treatment and the comparison of figures with the total population of that city, the number of accident cases treated and number of operations performed, giving the average number of each per day, and other information, intended to convey to the minds of the observers the measure of service rendered, and the fact that the hospitals were ready to serve the people of the community in cases of illness and accident.

The second section of the window displayed a portable x-ray apparatus, and an electric therapy lamp, a chlorine gas apparatus, and a number of samples of hospital supplies. The idea conveyed in this display was that the purchase of hospital apparatus and supplies constitutes a large part of the cost of hospital service to the community.

HOSPITALIZATION IN PALESTINE

Palestine has a total hospital bed capacity of 332, distributed in four hospitals as follows: Jerusalem, 121; Tel-Aviv, 101; Haifa, 56, and Safed, 54. Only in Jerusalem and Safed are the hospitals operated in buildings erected for hospital purposes. Both buildings belong to the Rothschild, and by it have been put at the disposal of the Hadassah Medical Organization. The other two buildings used are one for a hotel and the other a private residence for which rent is paid.

Each hospital has a dispensary and a laboratory attached to it, and all are departmentalized. All have departments for internal diseases, for obstetrics, for children and for diseases of the eyes. Jerusalem, Tel-Aviv and Safed have surgical departments; Jerusalem and Safed, x-ray departments, and Jerusalem has departments for gynecology and skin diseases and a dietetic department for child feeding.

A nurses' training school with accommodations for fifty nurses is attached to the Jerusalem hospital. The hospitals are all staffed with graduate nurses with the exception of three places.

SHORTAGE OF HOSPITALS FOR THE MENTALLY ILL

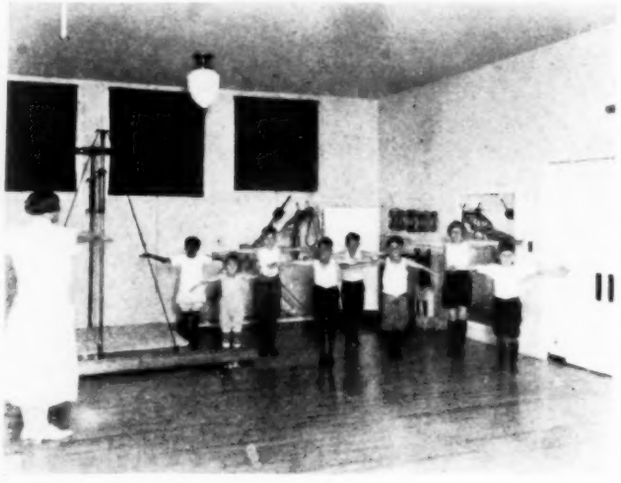
The shortage of hospital accommodation for the mentally ill in Illinois by April, 1924 had reached the appalling total of 6,000 patients. This means that 19,117 patients were crowded into quarters which at the conservative estimate are sufficient only for 13,482. Adjustments have been made by devoting space allotted to recreation and other daytime activities to beds.

PHYSIOTHERAPY DEPARTMENT OF CHILDREN'S HOSPITAL, LOS ANGELES, CALIF.

By LILY H. GRAHAM, Director of Physiotherapy Department, Children's Hospital, Los Angeles, Calif.

THE physiotherapy department of the Children's Hospital of Los Angeles has been in existence for the past four years. The beginning was made, of course, in a very small way with only a worker for a half day, but now the need for these treatments is so great that there are six full-time workers on the staff, and the number of treatments averages in the neighborhood of fifty-five a day.

In the beginning the department was housed in a small corner of the basement of the main hospital building where a room had been fitted up as a gymnasium. This was soon outgrown and larger and more airy quarters were demanded. The cost of a new orthopedic clinic building was met entirely through volunteer subscription. The doctors hold their orthopedic examination clinics in one end of it and the physiotherapy department has the other end. The department includes a fully equipped gymnasium and a treatment room in which are small booths for the individual treatments. The whole building is painted in white and is kept spotlessly clean.



A group of children doing the regular corrective exercises which are a part of the regular classwork in the physiotherapy department of the Children's Hospital, Los Angeles.

Children Brought to Hospital by Bus

The children in the hospital who are in need of these treatments receive them daily. Noticeable progress is made while the children are in the hospital. But after they are discharged the problem would be a difficult one except for the fact that interested people have devoted certain days each week to bringing to the clinic children whose parents, for one reason or another, cannot bring them. Recently a bus has been given to the hospital for this purpose and from now on the children will be brought to the hospital and, after the treatment, taken home again. In this way the child is certain of reaching the hospital at the appointed time and a more systematic schedule of treatments can be followed out.

Three mornings each week the orthopedic physicians of the city hold clinics and from these clinics the patients are referred to the physiotherapy department. A child must have a staff doctor's examination before he is admitted for treatment. This treatment, in a general way, consists of heat, applied by the use of large bakers, massage, exercise suited to the type of case, and ultra-violet ray, commonly known as quartz light. The types of cases treated are those found in any children's orthopedic hospital, posture, lateral curvature of the spine, infantile, spastic and obstetrical paralysis, club feet, flat feet, and fractures.

The children come two or three times each week, as the severity of the case may demand, and, as a rule, are most faithful about reporting. On Monday and Wednesday afternoons and Saturday mornings are the posture and scolioses clinics; on Monday morning and Thursday afternoon, the spastic clinics, Wednesday, cardiac cases and some posture; while all day Tuesday and Friday the infantile paralysis children receive treatment. Most of the cases mentioned are given class work, but since the infantile treatments must be given individually more time is assigned to these children than to the others.

Lay Stress on Individual Work

The policy of the department has always been to give individual work in the majority of cases whenever possible, as we believe better results are obtained in this way. Classwork, however, has many advantages to be gained through competition. The children report to the doctors' clinic for re-examination as often as necessary.

Complete records are kept for each child, showing his improvement or lack of improvement. When a posture case first enters, the patient's natural standing position is both photographed and traced. About two or three months later the process is repeated and in this way visible evi-

dence is given as to the real condition of the child. Once a week he is measured and weighed so that it is possible to judge the amount of exercise he is capable of taking. The children become very much interested in their work. To encourage them the exercises are graded, beginning with a group of simple ones, from which they are promoted to a harder class and are thence discharged from the third group.

Regular promotion or graduating days are held every two months. It is interesting to see how the children work and how hard they try to stand correctly that they may be promoted to a higher class. On Saturday mornings the gymnasium is filled to overflowing and as many as sixty children have been cared for in the posture clinic at that time. In fact so great is the demand for this kind of treatment for the undernourished and delicate child that more apply than can be efficiently cared for, and the number of new cases taken in during a month has had to be limited.

Muscle Re-education Work

The treatment of infantile cases differs from the general exercises given to the posture case, in that the former are exercises given for the re-education of individual muscles or groups of muscles. The records kept for these cases are just as accurate as those for the posture clinic. When a child is first sent in he is given a muscle examination and the muscles graded according to the strength shown. In a new case this examination is repeated in a month or six weeks, but in one of long standing where progress is slower, every three or four months is often enough.

The exercises are given in accordance with the findings of the examination. In the Monday morning and Thursday afternoon classes for spastic paralysis the children are first taken individually for some special muscle training, and when this has been done, those who are able to do so, are taken into the gymnasium as a class and are taught coordination exercises. The exercises are really well done considering the disabilities and the short time the classwork has been tried.

A speech clinic is just being started in connection with the spastic work and it is the hope of those in charge soon to add occupational therapy to the list of work.

About two years ago the need for including children in the surrounding towns became apparent. Since that time two workers have been sent to San Pedro two days each week, and one to Monrovia twice each month. The few treatments received in this way are obviously not sufficient but they give the worker a chance to teach the mother so that with her cooperation and help at home much can be accomplished. If at any time results are not so favorable as anticipated the parent is urged to bring the child to the hospital for examination and the child is required to report to the doctors' clinic as often as the doctor orders. In this manner the care given these children is almost as satisfactory as though they were brought to the hospital two or three times each week.

NO A, B, C RATING OF HOSPITALS

Many persons have the mistaken idea that hospitals are given a rating of A, B, C in the same way that the Council on Medical Education and Hospitals has classified the medical colleges. This fallacy probably grew out of the several attempts that have been made within recent years to devise a scheme for the rating of hospitals. None of these various schemes and plans, however, have been used by any agency in the hospital field. In fact, the organizations that have accomplished so much for the improvement of hospitals are all, with one accord, striving to eradicate the very idea that any A. B. C rating is made.

The principal agencies for hospital betterment designate which hospitals are approved as meeting certain minimum requirements. The American College of Surgeons publishes a list of the hospitals that meet its minimum requirements regarding laboratory records, staff organization and fee splitting. The American Medical Association, through its Council on Medical Education, and Hospitals, maintains a list of hospitals that provide acceptable internships. But no organization has assumed the responsibility of rating hospitals in ranks such as A, B, C or 1, 2, 3.

HEALTHY MENTAL ATTITUDE AIDS CURE

Mental attitude in any of the affairs of life is a most important factor. That sounds like an uninteresting generalization. But let us look at it from the point of view of the patient in the hospital.

It is an easily demonstrated fact that the patient who accepts his stay in the hospital with cheerfulness and hope aids in his recovery. Happiness, courage, faith, cheerfulness, hope and all of the kindred qualities have positive curative value. The patient who fears, broods, despairs, becomes angry and assumes the critical attitude retards his progress. Both the positive and the negative qualities to which we have referred have a definite physiological effect.

The hospital can furnish the expert skill essential to the patient's recovery. It can furnish the kindly and sympathetic nursing service. It can see to it that the surroundings are pleasant and that all comforts are provided. But it cannot furnish the patient with an "attitude of mind." That is entirely within the individual's own control.

Those who believe thoroughly in the power and efficacy of science in the treatment of disease believe also in the great power which mental attitude exerts in any case. They believe that the patient can help himself to more speedy recovery if he will have courage in his heart, if he will look upon the bright side of things where criticism, impatience and irritabilty have no place.—*The Reading Hospital Bulletin.*

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THE HOSPITAL VIEWED AS A MANUFACTURING PLANT

HOSPITALS are manufacturing plants designed and operated for the production of service to the community as a whole, and to the individual in the distress of sickness. As such, the same fundamental administrative rules apply to them as to any other manufacturing plant, and upon the observance of these rules depends the success or failure of the plant.

Viewed in this light, the function of boards of directors, whether they be directing the destinies of a plant which makes car-wheels or one which repairs the broken bodies and minds of humanity, are the same. The person who is in charge of the car-wheel foundry is a plant manager, while the hospital administrator is known as the hospital superintendent. At base, the functions of these officials are exactly the same.

From this viewpoint there is nothing occult or mysterious about hospital management. Granted an adequate technical background, the same qualities make for success in any kind of plant management. The same attributes of integrity, industry, steadfastness and humanity enter into both. Each requires an instinct for leadership and sound judgment, a keen sense of the relative values of the ideal and the practical, and an unquenchable thirst for improvement, recognizing that through the mutations of evolution come real progress.

The board of directors of a large manufacturing plant realizes fully that it is its function to lay down basic policies, to control the larger questions of finance and investment. These are delivered to the plant manager after conference with him and he is then required to work out the details of production and put them into force. The board of directors gives him ample authority and a free hand in doing this.

Alas, too frequently such is not the case with hospital boards of directors. Representative business men who would not dream of discussing the operations of the plant with a factory foreman seem to have no hesitancy whatever in invading the hospital and undertaking to discharge functions which are entirely those of the hospital superintendent. Some actually go so far as to stimulate and welcome direct correspondence from the heads of the various departments of the hospital. The result is that the hospital administrator finds it exceedingly difficult to discharge his functions and to maintain discipline and morale in his force, and many a man of initiative and vision has found it extremely difficult, if not impossible, under these conditions to perform his duty properly.

There has been a good deal of talk in the past about the necessity for adequately trained hospital administrators. That there is a crying need for definite courses of instruction for those who wish to enter this field cannot be gainsaid. Might it not also be a wise thing to have courses of instruction for those who are to be members of boards of directors of hospitals? In any event, they should be taught to govern their actions by the same general rules that apply to boards of directors of industrial plants.

AN EXPANSION OF MY PLEDGE AND CREED

AS THE logical outgrowth of My Pledge and Creed, the Touro Infirmary of New Orleans, La., at the graduating exercises of its school of nursing held May 16, 1925, initiated the use of My Pledge of Service.

In its seventy-two words this pledge embodies all of the highest ideals of the nursing profession. At the Touro Infirmary adherance to My Pledge and Creed is required of all employees and The Pledge of Service is required of those who are graduated from the school of nursing. The expanded pledge is printed herewith in the hope that it may find general adoption throughout the hospital field. It is believed that its use will be beneficial to the profession of nursing and will serve to increase and maintain the respect in which it is held by the general public.

My Pledge of Service

Standing thus on the threshold of my profession, I voluntarily dedicate myself to the wholehearted service of the sick in mind and body. Untiringly, with kindliness and patience, understanding and sympathy, shall I minister unto them in skillful obedience to those physicians under whose guidance I labor. I shall keep my mouth as it were with a bridle, and may God bless and aid my work, endowing my heart with faithful courage.

MISS NUTTING RESIGNS

THERE is arresting significance in the announcement that at the close of the present term, Miss M. Adelaide Nutting will retire as professor of nursing, Teachers' College, Columbia University, New York. Arresting, because of the amazing significance of the department Miss Nutting has developed during the past eighteen years. In thinking of Miss Nutting's resignation one has a curious feeling of having watched a courageous pioneer make a steep and difficult ascent, from a misty valley where the way was difficult and each step taken with timidity, to a broad bright plain that stretches farther than the mind or eye can reach. A plain traversed by numberless paths, branching and widening as they stretch forward to the horizon.

So recently as to be fresh in our memories, Miss Nutting's feet started on the almost unblazed ascent of nursing education, an ascent which should lead nurses to the point where they could see not alone their appealing opportunities but also the urgency and means of preparation that would enable them to meet these opportunities.

In the half light of knowledge, during those early days, only a few things could be made out, but they loomed large and clear. On one hand were ill and suffering people needing an intimate and sustained kind of care that would increase their comfort and supplement the doctors' prescribed treatment. On the other hand were eager, but unskilled, young women willing to give this care. The solution was fairly simple at first and something akin to an apprentice system was evolved. Doctors asked for relatively little assistance, for knowledge of therapeutics was not broad and treatment meant chiefly the giving of medicines. Patients demanded little, on the whole, for even normal existence was not padded with luxury as it is now.

In general, people were divided into two great groups, the well and the sick and only the sick were within the medical horizon. Nurses fed and bathed the bodies of "the sick" immediately under their eyes without knowledge of, or interest in, the conditions that produced illness. And they cared for bodies only, sublimely unaware of patients' minds. But this was as far as their help could go until medicine began to stalk ahead with breath-taking strides. Increasingly numerous and complicated procedures, with which the nurse must help, were employed on behalf of sick people. Ways and means of keeping well people well were devised and in their execution, also, nurses were needed. But facilities for training lagged far behind the opportunities for effective service and the nurses, like Alice, found themselves running very fast to stay where they were, at the doctor's side. Even the simple fundamentals of feeding and bathing sick bodies began to suggest great curative possibilities, if performed with understanding. Tact and resourcefulness in shaping the doctor's treatment to the individual patient became well nigh indispensable. And as people in all walks have become more exacting and luxurious, a certain delicacy or daintiness of care has become almost as necessary to the patient's welfare as the deft execution of nursing procedures. As for helping to preserve the public health, the nurse could be truly helpful only if

she had an intelligent understanding of the factors that caused and perpetuated ill health. In short, the nurse needed, and needed desperately, to be instructed more and more broadly if she was to meet the increasing demands made upon her by medical progress.

Florence Nightingale was apparently the first nurse to sense the importance to sick people of nursing education. Later, in this country, Isabel Hampton Robb, in the same spirit, set up undreamed-of ideals for nurse training. And now for nearly a quarter of a century Miss Nutting has been the standard bearer in matters of nursing education in the United States. With a curiously clear and prophetic sight she discerned possibilities, in those early days of mist and half knowledge, and rallied about her a believing little band that aided her step by step up that steep ascent toward the plain where the way of preparation and opportunity would be clearer. Every step was taken for the sole purpose of making the individual nurse more valuable to her patients.

As director of the Johns Hopkins Hospital's School for Nurses, Miss Nutting inaugurated the eight-hour system of duty for student nurses, believing that the patients were better cared for by nurses who worked eight hours than by those who were on duty twelve hours a day in addition to attending classes and lectures. She inaugurated the long probationary period during which candidates were given certain preliminary instruction before beginning their bewildering and exhausting duty in the wards. She abolished the system of paying student nurses at Johns Hopkins, and moved still farther from the apprenticeship idea by requiring a matriculation fee. Nurses were students, she believed, and were being prepared for a profession and were not in the hospital on the basis of exchanging labor for experience. If patients were to be safeguarded as far as was possible, through careful preparation of nurses, then all details of this preparation should be stabilized, and this implied that instructors be paid for their services. This led Miss Nutting to recommend that schools for nurses be separately endowed institutions. Expenses incurred in training nurses should not be met from funds intended for hospital maintenance.

Probably the most revolutionizing recommendation that Miss Nutting has made is that schools of nursing should become departments of universities in order that instruction might be carried on along sound educational lines. As the other innovations were opposed, so this plan has been opposed by those who have not fully understood its purpose. But like the other forward steps in nurse training, this one will doubtless justify itself, in time, through the increased helpfulness of the nurses who have profited by it.

The department of nursing and health, open to graduate nurses, founded on faith in the rightness of the idea, came into being in 1899 through the efforts of Mrs. Robb, formerly Miss Anna L. Alline, Miss Nutting and their supporters. For the first time in history nursing education had a place in an important university. Miss Nutting left her post at Johns Hopkins in 1907, and succeeding Miss Alline, took charge of the struggling little course, which now, as the department of nursing education, is a deeply intrenched and widely influential institution. Its curriculum covers all branches of nursing activities. Graduates from the department are literally to be found the world over and all are striving for the same ideal —efficient nursing service for women who are competent, because adequate training has been added to native ability.

It is something to have made that climb, through misunderstanding, opposition and lack of precedent, up to the brow of the hill where one can see the way ahead. The little band of coworkers who climbed along with Miss Nutting has grown into a large army spurred on by a serious purpose. She can settle back now, with deep satisfaction, and watch that increasing army march on and on over paths that she has cleared. Paths that lead through town and country to hospitals and clinics; homes, high and low; schools, factories wherever there are human beings, alone or in groups. And she will know that everywhere, both sick and well are profiting by her insistent pleading that every detail of every nurse's service should be shaped by intelligence, skill and understanding. CAROLYN C. VAN BLARCOM.

ROUND TABLE QUESTIONS

SO MARKED has been the interest shown in the little round table leaflets which we began to issue about two months ago that we have decided to include a similar series of round table questions in each issue of THE MODERN HOSPITAL. These questions will be based on the text matter of the issue in which they occur. They will serve a useful purpose in stimulating thoughtful perusal of the pages of the magazine as well as in directing the reader to definite answers to specific questions.

These round tables can be used to good advantage by the individual reader desirous of keeping abreast of his special field of interest and also by groups of lay workers in the hospital who gather for the study and critical analysis of their common problems. (See page 558.)

INGENUITY AND VARIETY MARK NATIONAL HOSPITAL DAY CELEBRATIONS

NATIONAL Hospital Day, as annually celebrated on May 12 in memory of Florence Nightingale, has reached such extensive proportions that some method of taking care of the large number of visitors who take advantage of the institutional open house must be devised in order to fulfill as completely as possible the purpose for which the day was planned.

The programs, both instructive and entertaining, which were held in nearly 7,000 hospitals throughout the United States and Canada on May 12, 1925, the fifth annual National Hospital Day, attracted such numbers of visitors that the planned activities of the many institutions had to be somewhat curtailed. Because of those waiting a hurried trip through the departments was necessitated, in which no thorough explanation nor demonstration could be given without delaying other visitors.

The idea of bringing the hospital and its service before the public has gained a great hold, both upon members of the community and upon institutional officials and has secured enthusiastic support and endorsement from many public officials. Open house was held in most hospitals, the elaborateness of the program being limited only by space and facilities.

Included in many of the programs given throughout the country were baby shows, essay and poster contests, instructive moving pictures, musicales, graduating exercises for nurses and departmental exhibits.

At Augustana Hospital, Chicago, the program was held in the nurses' home overlooking the addition to the hospital which is in process of construction. Piano and vocal selections and choral numbers by the Jenny Lind chorus of nurses, under the direction of Mr. Paul Hultman, entertained the visitors in the nurses' home while refreshments were served. The 1925 graduating class of nurses presented a copy of Augustana's first year book, which they prepared, to Dr. A. J. Ochsner, chief of staff of the hospital, to whom the volume was dedicated. In the evening from 9:30 to 10:30 p. m., the Jenny Lind chorus sang over the radio from WEBH.

Presbyterian Hospital, Chicago, held open house for visitors and served refreshments. A string trio moved from ward to ward playing selections for the patients. A similar program was offered at Ravenswood Hospital, Chicago, from three to five o'clock.

The announcement of plans for a new building, and the twenty-ninth annual graduating exercises were the fea-

A window display which drew the attention of crowds on National Hospital Day. It was arranged in one of the large stores of Lansing, Mich., by the Edward W. Sparrow Hospital of that town.

tures of the day's program at Chicago Memorial Hospital, Chicago. Seventeen nurses were given diplomas after they had solemnly accepted the provisions of My Pledge and Creed. Mrs. V. R. Hoener, superintendent, gave a short radio address on the importance of National Hospital Day in the community, from WMAQ.

A moving picture, "How the Fires of the Body Are Fed," was the main feature of the program at Wesley Memorial Hospital, Chicago, and was witnessed by more than 500 persons during the course of its showing. A reception was held in the main lobby with refreshments served by the Ladies' Aid Association. Articles made in the occupational therapy department were on display and were sold to guests in the roof garden.

Elaborate entertainment and refreshments were provided at Highland Park Hospital, Highland Park, Ill. A baby show with prizes for the infants nearest perfection was most interesting. Open house at the hospital drew more than 400 visitors who witnessed demonstrations in the x-ray department and inspected the poster contest display on health subjects. At the evening meeting Dr. William H. Walsh, executive secretary of the American Hospital Association, was the chief speaker, the moving picture, "How the Fires of the Body Are Fed," was shown, prizes for the poster contest were awarded and several musical numbers were given by the high school orchestra.

Cleveland Hospitals Combine to Celebrate

All of the hospitals of Cleveland, Ohio, combined their programs, each hospital featuring some one phase of hospital activity. In the evening services in memory of Florence Nightingale were held in Trinity Cathedral. The 1,100 guests at the City Hospital, which prepared occupational therapy and dietetic exhibits, shows the interest aroused by such an organized combination.

Pottstown Hospital, Pottstown, Pa., which had the best National Hospital Day Program in 1924, again prepared an entertaining offering. An extensive bulletin setting forth the ideals, needs and service of the hospital was given to each visitor, and moving pictures, a baby show for infants born at the institution, and a play were included in the day's activities.

Radio, both for publicity and reception of programs, played an important part in many hospital programs. The Fall River General Hospital, Fall River, Mass., held open house and broadcasted a radio program on hospital activities. A radio message from KOA brought open house and the prize baby show contest at the Colorado General Hospital, Denver, Colo., before the public. At the North Adams Hospital, North Adams, Mass., the radio was used for a musical program in conjunction with open house.

The Deaconess Hospital, Spokane, Wash., featured the opening of a baby-cribbed children's clinic for pediatric work in their National Hospital Day program. The twelve cubicles in the unit are all outside rooms located at the end of the building and receiving sunlight throughout the day.

As the community at Bluffton, Ind., is made up of the working class, National Hospital Day was observed on Sunday, May 10, at the Wells County Hospital of that town. Addresses, vocal and piano selections and group singing were included in the program. The Rotary Club of Bluffton entertained the nurses on Friday, May 8, with a banquet in honor of National Hospital Day.

In Terre Haute, Ind., the Union Hospital entertained the Rotary Club at luncheon in the hospital building. This meeting was one of several which were held to arouse interest in the hospital.

The clergymen of Brockton, Mass., and the neighboring towns were the guests of honor at the celebration held in conjunction with National Hospital Day at the Brockton Hospital. A tour of the grounds and the hospital was followed by addresses by the staff of the institution, which gave the visiting clergy a better insight into the workings of an up-to-date hospital.

An "alumni" homecoming for former patients was the distinctive feature at Broadlawns, Polk County Public Hospital, Des Moines, Iowa. Novel invitations in verse, illustrated by sketches, were sent to all former patients who responded by attending in large numbers. After the "alumni" had been registered and weighed they were conducted on a trip through the new wing and library and shown the newly finished river trail and croquet courts. Upon returning, a dinner was served in the hospital dining room. This was followed by addresses and a band concert.

All babies born at Our Lady of the Lake Sanitarium, Baton Rouge, La., were especially invited to attend the celebration. Three banks of Baton Rouge started bank accounts for these infants and the bank books were available on May 12. Seventy-five babies were there to receive the foundation of a saving account.

Under the direction of the American Red Cross, the United States Veterans' Bureau Hospital No. 72, Helena, Mont., held open house and furnished musical entertainment. Refreshments were also served by the Red Cross. The Municipal Hospital, Hartford, Conn., held open house, with the hospital building suitably decorated for the occasion.

Theatres Give Publicity to Day

Baby shows were held at Christ's Hospital, Topeka, Kans., Lancaster General Hospital, Lancaster, Pa., and St. Joseph's Hospital, Alliance, Neb. The latter institution held open house especially for babies born within the walls of the hospital. A group picture of the mothers and infants was taken in the afternoon with nearly 100 hospital babies in the group on the lawn outside the building. Ninety mothers of babies born at the Lancaster General Hospital were pictured with their babies in a group, following a baby party held from three to four o'clock.

Previous to National Hospital Day, Christ's Hospital, Topeka, Kans., had films shown in the local theaters which advertised the baby party and also gave publicity to the campaign for buildings funds. Four-minute speakers in all theatres invited the babies to the party. A baby clinic was held on May 12, and after the examination each mother was given a report of her baby's health. Toys were distributed to the babies born in the hospital during the past three years who numbered well over 300. Balloons, toy banks and talcum powder were given to each baby, and ice cream cones and animal crackers were served as refreshments by the student nurses.

The system of charting was explained to all visitors at the St. Luke's Hospital, Marquette, Mich., and the operating room supervisor demonstrated and explained an operating room arranged for an abdominal operation. Later, coffee and sandwiches were served by the student nurses.

In Miami, Fla., the James M. Jackson Memorial Hospital held an all-day reception in the hospital. Music was furnished by an orchestra from 10 o'clock in the morning until 5 o'clock in the afternoon.

A musical program in the parlor of the nurses' home, by the student nurses, featured the celebration in the Dr. W. H. Groves Latter Day Saints Hospital, Salt Lake City, Utah. In several department stores nurses were stationed to invite the public to the hospitals. The Rotary club featured National Hospital Day at their lunch-

eon at Hotel Utah, when hospital day, its purpose and history, and modern methods of nursing were explained to the members.

Displays in the pathological department, and fluoroscopic demonstrations in the x-ray department were enjoyed by all the visitors during their tour of the Lutheran Hospital of Manhattan, New York. Open house was held throughout the afternoon and refreshments were served by the ladies auxiliary.

In each of the United States and in every province of Canada the ingenuity, experience and cleverness of every hospital worker was tested to the utmost to find new ways and means of attracting the public to the institutions on National Hospital Day. National Hospital Day has reached a position of importance in the nation's calendar and public attention has been drawn to the numerous institutions for the sick and afflicted.

The American Hospital Association will award a certificate to the hospital whose National Hospital Day program was considered most meritorious, and the presentation will be made at the association's annual conference to be held at Louisville, Ky., October 19 to 23, 1925.

THE ROLE OF MY PLEDGE AND CREED IN INSTITUTIONAL LIFE

WHEN the editors of THE MODERN HOSPITAL magazine, after receiving counsel from leaders of thought in the hospital and nursing professions, presented My Pledge and Creed to the hospital world they hoped that it would meet with cordial approval and that hospital organizations would adopt it and bring it before their entire personnel. Yet the instantaneous response which greeted the pledge and which came from a wide range of institutions has surpassed their expectations.

The seed was planted at the twenty-sixth annual conference of the American Hospital Association, held at Buffalo last October, and the spirit of service which My Pledge and Creed advanced was carried back to the individual hospitals by delegates who attended the conference.

Since that time the uses to which My Pledge and Creed has been put in the hospitals throughout the country have been many. Letters, telling of the varied methods in which it is being used, have been received from many institutions. The novel manner in which some of these organizations are utilizing My Pledge and Creed may be gathered from excerpts of letters from hospital superintendents.

Used in Hospital Day Publicity

Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., writes, "The small copies of My Pledge and Creed have been sent out with Hospital Day publicity to each of thirty odd newspapers in Westchester County. One of the very large copies has been framed and hung in the front lobby in a conspicuous location. It is my plan to have a framed copy in each floor sitting room in the two employees' buildings being constructed here. I also have a supply of My Pledge and Creed on hand so that employees who wish to have copies for framing may have them."

In Muhlenberg Hospital, Plainfield, N. J., a copy of My Pledge and Creed is placed over every nurse's desk, in private corridors, in all wards, in the medical staff room and in the nurses' recitation room. "The pledge has been commented on by both nurses and doctors, who think it the most dignified expression of service ever given to the profession. Our patients and visitors read it with reverence, and I believe it is a daily inspiration to all our people for better service to the sick. To me personally it gives daily renewed courage to carry on." These are the words of Miss Marie Louis, superintendent of the hospital, in commenting upon the place of My Pledge and Creed in the hospital field.

In Evanston, Ill., at the Evanston Hospital, Miss Ada Belle McCleery, superintendent, has placed copies of My Pledge and Creed throughout the hospital building and nurses' home. A small size, three and one-half by five inches, has been ordered to place in the pay envelopes of the employees every week.

Put It in Pay Envelopes

The importance of keeping My Pledge and Creed before the eyes of employees is stressed by Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., who has had framed copies of the pledge hung in prominent places where employees may see them.

Miss May A. Middleton, business manager, Methodist Episcopal Hospital, Philadelphia, Pa., has a copy of My Pledge and Creed placed directly over her desk where it is a source of inspiration. She states, "We have recently put two large copies where they will come to the attention of the nurses, one in the class room and one in the office of the superintendent of the training school."

"Yes, we are using My Pledge and Creed throughout our hospital. We have had twenty-four of them framed and one is placed in each of our chart rooms, one in the main office and one in the nurses' home. The thought expressed is very fine and I trust will leave its effect upon those who read," writes E. E. King, superintendent, Baylor University Hospital, Dallas, Texas.

Visitors Favorably Impressed

My Pledge and Creed not only benefits the personnel of the hospital but makes an impression upon visitors according to Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, who says in his letter, "I am using My Pledge and Creed by having copies framed and placed at each nurses' station and in each office throughout the hospital. Many visitors have commented upon them and I believe that it is doing much good beyond the hospital's walls."

At the W. A. Foote Memorial Hospital, Jackson, Mich., My Pledge and Creed has been distributed to every department in the institution. Miss L. Winnifred Seckinger, superintendent, writes that it is being used in the following manner: "We have My Pledge and Creed hanging in the kitchen, in the out-patient department, in the class-room, in the main office, in the bookkeeper's office, in the wing of the operating rooms and in each of the chart rooms. I also have a copy placed in my own office where it is seen daily."

THE HOSPITAL AND COMMUNITY HEALTH*

By JOHN R. HOWARD, Jr., Superintendent, New York Nursery and Child's Hospital, New York, N. Y.

WHILE the interrelationships of the hospital and the community can most easily be plotted for a small community with but one hospital and relatively few social or health organizations, it is the duty of every hospital to realize its relationships to its community, no matter how complex they may be.

A well-rounded hospital community program, moreover, might best be worked out for a general hospital; but special hospitals, also, have community responsibilities, and in the case of maternity or children's hospitals, this responsibility is intimate and extensive.

The hospital chosen for this study is an institution with the following general activities: A lying-in and gynecological service of 200 beds, caring for 3,700 mothers and babies a year, and 365 gynecological patients; a children's service, of eighty beds, caring for 1,000 patients a year; an outdoor obstetric service, caring for 1,300 mothers and babies a year; an infant asylum, where foundlings and waifs under two years of age are received and conditioned, and placed out in foster homes under the supervision of doctors and visiting nurses.

For the purpose of this study, that part of the work falling under "infant asylum" will be disregarded; although it may be borne in mind that the admission through the hospital of 300 such babies a year, and the physical supervision of 700 a year in boarding homes, gives the institution an unusual basis for observation and instruction.

The community chosen is a metropolitan area of three and one-third square miles, with a population of 350,000—35 per cent foreign-born whites and 6 per cent (21,000) negroes, the section nearest the hospital being exceeded in density of population by few districts in the world, (656 persons per acre).

The social complexity of the district is indicated by the following partial list of agencies there located: 11 hospitals with dispensaries (5 general, 6 special); 11 dispensaries (separate); 7 baby health stations; 7 nursing centers; 9 family welfare organizations; 7 social settlements; 9 day nurseries; 21 public schools; 68 churches.

It seems a hopeless task for one hospital to work out its community program in such a district, without first organizing all the health agencies to work together. Various experiments are now under way in metropolitan districts looking toward the coordination of health efforts. So far, similar experiments in limited areas have produced excellent results, but at a cost that no organization or group of organizations can afford to extend beyond the limited area.

Meantime, what is the local metropolitan hospital to do? Some of the most successful examples of coordination of social effort have been brought forth, not out of organization of agencies, but through the service of one agency to many. Let the hospital begin by asking, "How can we serve the community?"

The functions of a hospital are:

The care of the sick.

The training of those who care for the sick.

The prevention of disease, and constructive health building.

In how far does the maternity and children's hospital in question fulfill these functions?

An obstetric hospital should provide not only for the care of women in childbirth but for all gynecological conditions attendant upon or following childbirth. This the hospital does. Any obstetrician who comes up to the high standards of the hospital may be appointed to the courtesy staff, and have the privilege of bringing private patients. The hospital delivers ward patients in their homes as well as in the hospital, the controlling factor being the physical and social condition of the patient, and not the lower cost of home delivery. The home deliveries are attended by graduate nurses and delivered by students under the supervision of a member of the resident staff.

Pre-natal and post-natal clinics are conducted daily; patients are required to register early, are given prenatal instruction by doctors and social service workers in clinic and home, and all conditions of the mother bearing on childbirth, including venereal disease, are checked up and treated by the institution.

In a home where a mother is in childbirth there is need for household care as well as visiting nursing care. Where such is not present in the person of a friend or relative, and in the absence of any visiting houseworkers trained and provided by a separate social agency, such workers should be provided by the hospital, and paid for by the patient, when able. In Brattleboro, Vt., there has been in effective operation for many years an agency which trains, registers, employs, and furnishes any kind of service needed in a home in which there is sickness. This has been particularly successful with obstetric cases, and might well be developed by a maternity hospital.

Services to Children

The institution now provides hospital and dispensary care for sick children, from the premature to the child of twelve or over, and dispensary care and home instruction for well infants delivered by the hospital staff. The intimate relations of the obstetric and pediatric services, and of the families of "born-ins" with both, result in a hospital service largely devoted to infants.

The only restrictions relate to contagious diseases, which are not accepted, and which—in a city of many institutions—are properly cared for in a separate institution.

While it is proper to limit a pediatric service to noncontagious cases, a hospital so limited should provide for any condition arising in a child already under care. To transfer a child who is in critical condition and under delicate scientific treatment to an institution for contagious diseases is wrong. Such a child should remain in the original institution, and proper isolation rooms be provided.

Tonsillectomies break into the bed capacity of a hospital unless a unit is set aside for them, for continuous use. That is one reason that the beds capacity for this purpose throughout the city is hopelessly inadequate. To help meet this city-wide need, and to meet it more promptly for its own patients, this institution should provide such a unit.

A hospital in the center of an industrial district is no place for convalescent care, even if there is room and a suitable roof, and ultra-violet rays are a poor substitute for sunshine. Every children's hospital should have a convalescent country branch.

Because of lack of room surgical cases are restricted to patients already under care in the hospital or dispen-

*Essay which received honorable mention in The Modern Hospital Publishing Company's prize essay contest on "The Interrelationships of Hospital and Community," which closed November 1, 1924.

sary. This is particularly true of tonsillectomies. Orthopedic conditions are probably better referred to one of the several orthopedic hospitals.

Children's Clinics

The children's clinics include medical, cardiac, dermatological, nutrition, protein sensitization, venereal, and well babies. A cooperative neighborhood dental clinic meets the more urgent dental conditions. Five social service workers are assigned to the children's clinics, and a scientific follow-up system has produced results that have called forth favorable public comment.

While the cooperative dental clinic helps meet the need for diagnosis and care of the teeth, no children's clinic should be without its own diagnostic dental clinic. In this district, the dental clinic would have to do treatments as well, as the present dental clinics are obviously inadequate for those unable to pay a private dentist.

When a child attending one of the clinics becomes sick enough to be kept at home, does not use hospital care, and yet needs a doctor, it is unsound practice to refer the patient to a local doctor. To build up a careful system of treatment, and then throw it over at the first crisis, is wasted effort and perhaps wasted life. A special service such as pediatrics, just as in the case of the obstetric service in this institution, should arrange to have, at need, children visited in their homes by its doctors as well as by its nurses. This would probably mean a paid staff, but it would be a wise investment. Furthermore, the resident staff should be enlarged to include this important educational function among its duties and privileges.

An important development of the use of foster homes, heretofore used only for children afflicted with social ills, is the placing in homes of two classes of children:

(1) Children who need a special series of treatments which cannot be obtained otherwise, because the families are uncooperative, or the institutions to which they might be committed do not afford such treatment.

(2) Children who have been exposed or show a disposition to tuberculosis for whom there is no place in preventoriums.

Both these need specially selected homes and extra supervision. These have proved successful and economical.

Economic Aspects

The institution now provides bed care for patients of small means in the wards, for the well-to-do in private rooms and for persons of moderate means in semi-private wards and cubicles. Public ward obstetric patients are charged a flat rate for pre-natal care, delivery, and two weeks' hospital care. Semi-private ward patients who cannot afford an obstetrician's fee are admitted on the house service at a flat rate for complete care and delivery.

In the dispensary only patients who cannot afford a private physician are received, and the fee per visit is twenty-five cents. The hours for the dispensary are mornings for children and afternoons for women.

The cost of the treatment of children's ailments—number of visits, specialists' fees, laboratory and x-ray tests and treatments—is often so great that persons of moderate means cannot afford it, and do or should come to the dispensary. Pay clinics for such should be developed on the principles already proved proper in many places.

Evening clinics for children seem unnecessary, but evening obstetric clinics for working women are essential, not only because married women work, but because unmarried mothers—for whom this particular institution was in part founded—need early and easily available advice.

Community Control of Bed Capacity

The relation of the bed capacity of a hospital to the needs of its community is basic. It should never be left to the whim of a benefactor, the enthusiasm of a board of trustees, or the ambition of a doctor. In the past, the demand for hospital beds so far exceeded the supply that there was no danger of overbuilding. Today there is. The inherent impulse of a hospital to grow (as of any institution with walls) is so impelling that the decision as to number of beds should rest *outside* the institution—either through public control as with a state board of charities, or through private control as with a health organization in a small community, or a community chest or united hospital association in a larger community.

No hospital bed should be added unless it is within the community's resources to support it, and until its need is proved under a realizable system of home care of the sick, and public health and preventive measures.

This institution called upon a central hospital agency to diagnose the need of this district for more beds for obstetrics and pediatrics. Not satisfied with the completeness of the facts presented, the hospital called in an expert in hospitalization, preventive medicine and public health, a man whose opinion, based on facts, would be accepted by the community.

This man made a study of the entire district, its population, growth, nationality and economic changes, hospitals and health agencies, death rate and birth rate. He ascertained which areas were served by this hospital and which by others, what the future of the population and of other hospitals was likely to be, and other related facts. From all this he determined whether the present location was the proper site for such an institution for years to come; whether more beds were needed now or were likely to be needed in the future—and many other matters of intense practical value to the hospital.

It is not necessary to report these findings here, except to say that it showed the present location sound, the number of private beds sufficient, and the number of ward beds inadequate, particularly after the contemplated removal of the only other maternity hospital in the district. The main point is that the board of directors had such a study made preliminary to determining a program for the institution, and that they asked for it not for purposes of promotion, but to be sure of the facts from the community's point of view.

Training of Personnel

This hospital offers a staff service in obstetrics and in pediatrics with annual appointments, the hospital and ward staffs being one unit. Monthly staff meetings are held when all hospital cases, ward and private, are reviewed. A central history system is maintained where ward and dispensary histories are filed together.

The resident service in obstetrics and in pediatrics for doctors who have completed general internships includes a systematic course in wards, dispensary, homes (for obstetrics), operating room and laboratory, with weekly staff conferences and monthly reviews of all cases.

There is a teaching service in pediatrics for a medical school, the professor of pediatrics being the director of the hospital pediatric service.

The obstetric practice for students of two medical schools includes delivering patients in their homes under supervision, observing in wards and delivery rooms, as-

sisting in clinics and laboratory.

Living quarters for women as well as men on the resident staff should be provided, for if there is any department of medicine where women belong it is certainly pediatrics.*

Instruction should be given students in the social side of medical problems, and conferences of doctors, nurses and social workers on medical-social cases.

Affiliation with medical school on obstetric service should be similar to that on pediatric service, to make further use of the excellent teaching material, and to obtain for the patients and the hospital the scientific resources of such a school and the inspiration of educational procedure.

Courses for Practising Physicians

Clinics for neighborhood physicians should be held both in obstetrics and pediatrics, with the honest intent of serving them and through them the community.

A consulting service for local physicians should likewise be offered, with every attempt made to win their confidence, and with strict regard to their rights.

While a few physicians from other towns and states who want to "brush up" on obstetrics or pediatrics can and do accept resident positions for six or nine months, many who need this service cannot afford so long an absence from practice. Nowhere but in a chlidren's or maternity hospital can a short course in these subjects give the needed result. Every special hospital should provide definite opportunities for short-term post-graduate courses.

Education of the Nurse

The hospital provides three months' courses in pediatric and in obstetric nursing to training schools and has, now, nineteen such affiliations, (thirteen pediatric, four obstetric, two combined), providing training for 268 nurses a year. This includes ward and private care, well and sick babies, pre-natal instruction in dispensary, home delivery and post-natal nursing, and medical nursing, and social-medical lectures.

The same courses are open to a limited number of post graduate nurses, the demand exceeding the vacancies.

There is an eight months' course for nursemaids, which supplies a demand for nursemaids trained in the care of infants and children, and takes care of some of the elementary tasks, which pupil nurses receiving special training should not be required to do.

The courses for pupil and graduate nurses and for nursemaids are limited by the size of the nurses' home. The hospital could use more of all three, replacing practical helpers now employed and living out, thereby giving student nurses more of the home and social side of nursing. The demand for affiliations in obstetric nursing are likely to diminish rather than grow, unless there is a change in the attitude of training schools or state authorities on this important branch of nursing; but the demand for pediatric affiliations is marked, the demand for post-graduate courses is continuous, and the need and demand for trained nursemaids is evident.

To meet the needs of this community and of many others for special training of nurses, particularly in pediatric nursing, an enlarged nurses' home is clearly indicated.

Program of Disease Prevention

For a hospital to occupy itself with the care of the sick without contributing anything to the prevention of disease is to fail in its duty to the community, and to neglect one of the vital factors in the education of the young physician and the stimulation of the whole staff.

The laboratory student and the clinician are rarely found in one man. The attending staffs of most hospitals are made up of clinicians. To make the most of the research material in a hospital, there should be a department devoted to it, or at least an individual with the essential knowledge and enthusiasm to direct it.

On the obstetric service of this institution research is incidental to the care of patients, although the staff is quick to prove and apt to develop new methods of scientific treatment.

On the pediatric service, because of its relation to and financial aid from a medical school, there is one of the best research laboratories for children's diseases in the country, amply manned, and directed by a clinician who is a laboratory student.

The hospital is in need of a research department for the obstetric service with necessary laboratory and personnel.

In addition to laboratory research, there should be in every hospital a constant checking up of end-results, and assembling and correlating of the mass of vital information that goes into individual histories and is there so often lost. There should be a man appointed on each service, for this purpose, to work on a definite system and schedule.

Preventive Medicine and Education

It is difficult, when it comes to the individual patient, to tell where the care of the sick ends and the prevention of disease begins. From the community standpoint, "how to keep the hospital beds full" should read, "how to keep hospital beds empty," or how to reduce patients needing bed care to the minimum. For this reason the work of the dispensary is more vital than that of the wards. This does not apply to maternity cases, though even there the obstetricians tell us that pre-natal care is more important than the delivery.

In the obstetric service of this institution, prevention and care go hand in hand from the earliest registration of the patient until the mother is discharged well, and turned over to the pediatric clinic for further advice and supervision for her baby. This includes, in addition to examination and instruction of the mother in the pre-natal clinic: Home instruction by social service nurses; check-up on health of all members of the family; referring of husband to another dispensary, where indicated, and follow-up for report and subsequent treatment; and referring family to welfare agency, when indicated.

In both obstetric and pediatric services the family, not the individual patient, is the unit of attention, and all unfavorable conditions, physical or social, which cannot be treated by this institution are referred to where they can be treated.

In addition to the education of the families in their homes, there are classes in nutrition at the hospital for undernourished children and for their mothers, and special classes for cardiacs, both of which are limited in kind and extent by inadequate space. The doctors are eager to extend the educational program, and the social service committee ready to provide the workers.

The next step in educating the families of the sick is to educate the families of the well. Once the educational function of a hospital is recognized, this transition will be easily made by the community and by individuals.

The well babies' clinic is limited to the babies delivered by the hospital staff, and even the work for them is crowded out by the growth of the clinics for sick children.

*Recently a residential position in pediatrics has been provided for women.

It would be a greater service to the community to follow through childhood every "born-in" than to care for the children of the district only when they become sick; but both are essential. The dispensary should be enlarged to make room not only for all the born-in babies, but for all the well babies of the district who cannot obtain periodical health examinations and advice elsewhere.

Examination of Pre-school Children

The physical examinations given in school might safeguard children of school age, although the personnel for the follow-up of such examinations in this district is woefully inadequate. But for the children of pre-school age, there should be a place in every children's dispensary, and the whole educational program for them and their mothers should be provided.

Whether periodical health examinations for women of the district should be offered by such a hospital is a question. Those likely to avail themselves of it are potential mothers, and the people of the district are used to the idea of well people—expectant mothers and babies—coming to this dispensary. For this reason, and in the absence of other health clinics for women in the district, such should be tried. The reluctance of an unmarried woman to go to a maternity hospital could probably be overcome, and the very existence of a health clinic for all women would make it easier for the unmarried woman who apprehends pregnancy.

Cooperation of Health Agencies

Intimate relations already exist between this institution and every agency in the district. All cases are registered with a central clearing bureau so that any agencies interested in a family are immediately known and consulted. The superintendent of the hospital is chairman of the chief family welfare committee of the district and the social service committee has made a point of being represented in the various health agencies working in the district.

The question of which agencies should institute which activities, and what should be done in common, demands a *permanent neighborhood conference of health and family welfare agencies.* The latter are included because conditions of health are unalterably bound up in social conditions of family and neighborhood, and because a large part of the time of family welfare workers is devoted to obtaining treatment for physical ills.

Occasional conferences are now held. Those who are afraid of the League of Nations may think this method the safest. They have resulted in such temporary cooperative efforts as an annual health show, each agency exhibiting its service and methods, and in such permanent activities as a cooperative dental clinic. But beyond the fine spirit thus engendered, and the remarkably intimate mutual knowledge and give and take, there would undoubtedly be much gained by a permanent organization, even without a headquarters or budget. Not only overlapping work but overlapping plans could be checked, and many of the unmet needs of the district provided for without additional equipment or expense. Where such needs require additional expense, the group endorsement of the project would help obtain the funds.

In its care of the sick a hospital can do everything for its patients except compete for them with local physicians and other hospitals by advertising or canvassing. One health agency in this district, conducting an intensive pre-natal service, and making a house-to-house educational canvass of a restricted area, has reported that in the third year of the experiment ninety-five per cent of all the deliveries in that area were cared for by the two maternity hospitals. For the entire district served by these hospitals this percentage is only twenty-six. This important service should be extended to the entire district, but the one agency cannot finance it. Perhaps it could be done cooperatively. Perhaps the nearest approach to it is through an existing city-wide nursing service. Only in such a group conference could such a vital question be wisely settled.

Financial Support

Such a program as that suggested by the foregoing would require large funds for buildings, maintenance, and personnel. That it would be of more value to the community than funds devoted exclusively to orthodox hospital activities, there is no doubt, but also there is no doubt but that funds for it would be harder to obtain. There is inevitably more appeal in caring for the sick than in keeping people well. The people who see it the other way are not usually the ones with money.

This particular institution has to have large funds anyway. It needs new buildings without any program of enlargement—to maintain its present standard of care for its present number of patients. Its income from patients has reached the maximum, being eighty-two per cent of its total income, and its small endowment (yielding five per cent of the total income) and annual donations are insufficient to meet the growing needs.

No hospital in such a community can give scientific care in modern buildings, with adequate dispensary and social service, to patients of all walks of life, according to need, and at what they can afford to pay—without generous aid from a generous public. Private patients cannot and should not be made to pay the entire deficit in the care of those less fortunate.

It is becoming more difficult every year, for all hospitals, to make up the deficits through appeals for individual donations. There are only two ways out: increased endowment, or the united fund-raising of many agencies.

The community chest points the way to what seems the most effective manner to raise funds according to the individual agency's need, and—what is equally important—to expend funds according to the needs of the community.

The Federation of Jewish Charities in New York has shown how one people in a complex community can do this for its own agencies. The United Hospital Fund of New York has attempted for many years to do the same thing for the hospitals, but comes far short of the mark.

To raise an adequate endowment fund for a hospital in a city of many hospitals, and in the absence of particular family or church interests, requires: outstanding merit and publicity; a drive for funds led by a person or committee of compelling force and position, engineered by an expert money-raiser; or that happy chance that comes to some through interesting a person of great means and vision.

The institution in question has not the second means, it hopes for the third, but pins its faith on the first, namely, doing the best work it knows how with the funds obtainable, and acquainting the public with its accomplishments and hopes. This means may well lead to either of the others described.

Fortunately, the report of the hospital and public health expert already referred to furnishes a splendid basis on which to proceed.

While, as pointed out, to keep the well in health provides a less stirring appeal than to care for the sick, it is just possible that some individual or foundation with

vision will see its opportunity to establish the first community health center in a metropolitan hospital established for the protection of motherhood and childhood and devoted to the education of the individual, the family and the community in the laws of life and the preservation of health.

In a metropolitan district of many hospitals and health and social agencies, the individual hospital, without waiting for the ideal community health plan to be discovered (if there is such), should address itself to the task of making the hospital serve the community to the fullest possible extent. Examination of its existing activities in the light of the needs of the community will discover many ways in which it can extend its usefulness. This examination should cover the care of the sick, the training of doctors and nurses, and the prevention of disease through research and through the education of patients and their families and such other members of the community as the institution comes in contact with.

In making such an examination it is essential to call into consultation a representative of the community's health interests, in order not to develop bed capacity or activities which are not needed, or which could better be developed under other auspices.

Such a survey, by a recognized community representative, whether an individual, or—better—an association of hospitals or other agencies, constitutes the strongest possible basis upon which to obtain the funds necessary for the resultant plan.

Any plan should include not only close cooperation with the individual health and social agencies of the district, but a permanent association of such.

A maternity and children's hospital is peculiarly suited to be the educational health center of a neighborhood, and, with the consent of the other neighborhood agencies, should be able to establish and finance what would prove of great service to the local community and an important contribution to the science of public health.

LIBRARIAN BANS THRILLERS

The literary taste of hospital patients has been analyzed in a recent report by Ruth Schmeisler, librarian, St. Luke's Hospital, Chicago.

Contrary to popular opinion, Miss Schmeisler finds patients in the shadow of death, instead of fortifying their faith by reading the scriptures or religious writings, prefer to follow their own bent in literature, and read the kind of books in which they are most interested.

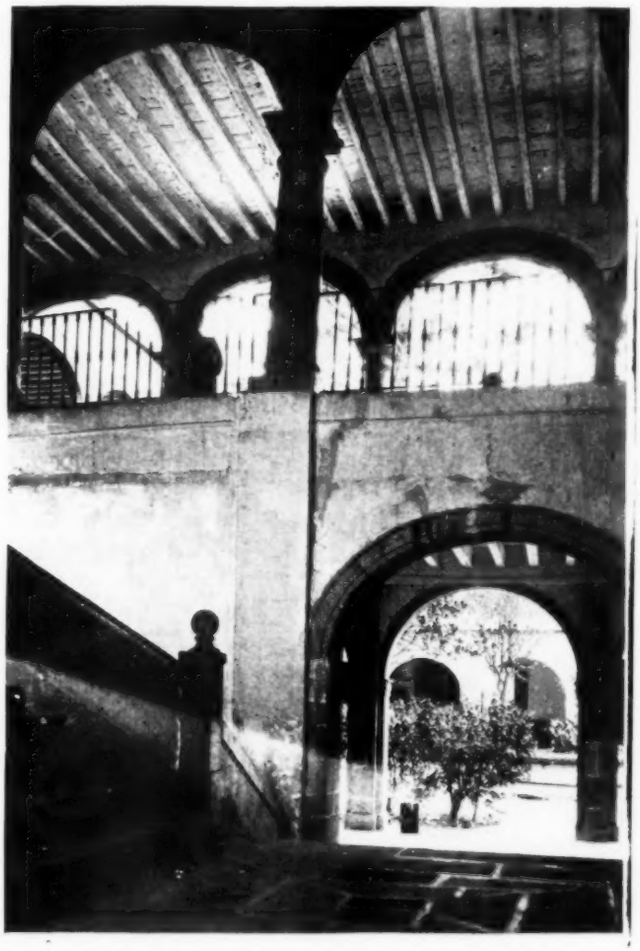
Poe, the often requested, is proscribed as being overstimulating, especially to patients with weak hearts. Anna Katherine Green, Arthur S. Reeve and others of the thrill school, likewise are barred from the shelves.

"We direct the reading as we do the food," says the librarian. "Nurses always are consulted before the patient is allowed to have books. Detective stories and books that savor of excitement are excluded from the literary diet of our patients."

Jefferson County Armory, Louisville, Ky., which will be the scene of many of the meetings at the next American Hospital Association convention to be held at Louisville, October 19 to 23, 1925.

THE OLDEST HOSPITAL IN AMERICA*

ACCORDING to a tradition reverently cherished in the Hospital *de Jesûs Nazareno* of the city of Mexico, the first interview celebrated by the eminent conqueror Don Hernán Cortés and the Aztec Emperor Moctezuma II, was held in front of the spot where now stands the charitable institution. In front of the entrance to the hospital the conqueror dismounted his prancing horse and



Main stairway leading to the courtyard balcony.

the Aztec sovereign descended from the royal litter carried by noble Indian chiefs. Here they met and greeted and Moctezuma received from Don Hernán Cortés a necklace as a proof of his respect and friendship.

Founded in 1527

As a remembrance of that great act, which meant the first step toward the conquest of Mexico, Cortés founded this hospital. "In order to unburden his conscience from any charge or any sin and to expiate his faults," (clause II of his will). Some historians believe that the hospital began to render service before the year 1527; but according to a commemorative plate on the façade of the edifice, the fourth centenary of the foundation of the hospital will be celebrated in 1927.

The project for the construction of this ancient building, some historians claim, is due to Pedro Vazquez, an architect whom the conqueror mentions in his will; but some others assure us that the plans were made by Cortés himself, who, anticipating his epoch proved his great ability not only as a warrior, as a diplomat, as the pacifier of this kingdom, but even as an engineer and architect.

The hospital was originally called the Immaculate Conception being known by this name until about the year 1630 when a miraculous image of Jesus of Nazareth was won in a contest between five institutions. As stated in the will of the donor, Doña Petronila Gerónima, the name was changed to the Hospital of Jesus of Nazareth.

According to history, the first Jesuits who came to Mexico, in the year 1572, lodged in this hospital on their arrival in Mexico City from Vera Cruz. They made the trip by foot suffering every privation, as they were extremely poor. The coming of these missionaries was considered the most important event of the century of the conquest.

The building in which the hospital is situated is of colonial design and is well lighted and airy. The infirmaries form a transept and where they join the little chapel is located, which is convenient for those who wish to attend the religious ceremonies without having to leave their respective rooms. In the chapel the sepulchre of Hernán Cortés was erected in 1794 by order of the viceroy, Count Revillagigedo. All that was mortal of the conqueror lay there in peace until August 12, 1822. On this date it was agreed to exhume the remains and to destroy the mausoleum.

Under Italian Auspices for Three Centuries

Dating from January 30, 1629, the masculine line of the conqueror was extinguished and the patronage of the hospital passed into the hands of one of the most distinguished families of Sicily and afterwards of Naples. For this reason the hospital has been under the protection and shelter of an illustrious and honorable Italian family for nearly three centuries. The dukes of Monteleone have, ever since the consummation of the Mexican Independence, given power to administrate the institution exclusively to Mexican citizens.

In this hospital patients who are not suffering from contagious diseases are given attention without regard

A view in the infirmary.

*This article and the pictures which illustrate it are published by the courtesy of Johnson & Johnson, New Brunswick, N. J.

View of the upper corridor facing the courtyard.

to race or creed, as provided by its founder, Don Hernán Cortés. A considerable part of the funds bequeathed by Cortés are still held by the hospital.

The building in question is unique in curiosities, among which are the cedar panelled ceiling of the sacristy forming different casetones, and a table made of one single cedar plank, extraordinary because of its dimensions—eight feet in diameter by three inches in thickness.

As a portion of the building has been ruined, the reconstruction of it has been undertaken to adapt it to modern conveniences and yet retain its beautiful and rich colonial style, so that it can be preserved as the unique model of the colonial architecture of its time.

HOSPITAL SOCIAL WORKERS ANNOUNCE PROGRAM FOR DENVER MEETING

The program for the annual meeting of the American Association of Hospital Social Workers to be held at the Shirley-Savoy Hotel in Denver, Colo., June 8 to 16, has been announced as follows:

Monday, June 8, will be given over to the executive committee which will meet in the Indian room, Shirley-Savoy Hotel from 10 to 12:30 p. m. and from 2 to 5 p. m.

Tuesday will be given over to the transaction of business. The morning meeting from 10 to 12:30 p. m. will be taken up with the reports of district chairmen and committees. The meeting will be resumed at 2 p. m.

Wednesday morning's program will be taken up with the address of the president, Miss Mabel R. Wilson, Children's Hospital, Boston, Mass., and two talks on "Follow-up" by Miss Mary H. Combs, director of social service, Brooklyn Hospital, Brooklyn, N. Y., and Miss Helen Myrick, organizer of psychiatric social work, Illinois Society for Mental Hygiene, Chicago, Ill.

The afternoon session will be opened by a paper on "Some Social Deductions from Medical Diagnoses," by Miss Helen Beckley, director of social service, Michael Reese Hospital, Chicago, Ill., and an address on "How Hospital and Community Workers Can Best Meet Their Mutual Problems," by Miss Ida M. Cannon, director of social service, Massachusetts General Hospital, Boston, Mass.

Thursday, June 11, from 9 to 10:30 p. m., the section on psychiatric social work will hold a business meeting, followed by a luncheon from 12:30 to 1:30 p. m.

The afternoon session will be given over to a round table by the section from 2 to 3:30 p. m. on the use of boarding homes as a part of treatment in psychiatric social work, under the leadership of Miss Mary E. Whitehead, Institute for Juvenile Research, Chicago, Ill. Another round table will be held from 3:30 to 5 p. m. on the subject of the co-operative work of a child guidance clinic with other welfare agencies, led by Miss Hester B. Crutcher, chief social worker, Child Guidance Clinic, Minneapolis, Minn.

The general sessions of the afternoon will also be taken up with round tables. From 2 to 3:30 p. m. the subject under discussion will be "The functions of hospital social service committees under the leadership of Mrs. John E. Jennings, chairman of social service committee, Brooklyn Hospital, Brooklyn, N. Y. From 3:30 to 5 p. m. the subject under discussion will be the content of instruction in medical social work for student nurses, by Miss Mabel R. Wilson, director of social service, Children's Hospital, Boston, Mass, and another on "Some Problems of Therapeutic Relief," led by Miss Deborah Barus, director of social service, Union Hospital, Fall River, Mass. Tea will be served at the Children's Hospital at 5 p. m.

The section on psychiatric social work will hold a general session Friday, June 12, from 2 to 3:30 p. m. Dr. Lawson G. Lowrey, director, Child Guidance Clinic, Cleveland, Ohio, will be the speaker of the occasion. From 3:30 to 5 p. m. will be a presentation of a prize case.

On Monday, June 15, from 4 to 5 p. m., an address will be given at the Central Presbyterian Church by Mrs. Paul Smith, social service department, Bellevue Hospital, New York, N. Y., on the subject, "The Organization and Social Work of an Evening Cardiac Clinic."

The conference will close on Tuesday, June 16, with a luncheon on Lookout Mountain from 11 a. m. to 3:30 p. m.

FRIEND OR FOE

The majority of the people consider me a friend; they come to me daily, though I conduct a great germ exchange.

Many people come to me daily and exchange the germs of any disease they may have for those of someone else.

The person leaves his germs with me and I give to him whatever else I may have on hand.

Among the germs that are left with me for free distribution are influenza, whooping cough, pyorrhea, venereal disease and tuberculosis.

I belong to the great unwashed.

I am a law breaker.

I am a public menace.

But young people, old people, prosperous people, poor people, ignorant and intelligent people, and flocks of school children, all come to my exchange.

I am the PUBLIC DRINKING CUP.

MY TWENTY-THIRD PSALM

The sanatorium is my refuge,
Of care I shall not want.
The doctor maketh me lie down on a soft bed,
And there I shall rest.
My nurse prepareth a tray before me,
Therewith to satisfy my appetite.
Another doctor anointeth my body with sunlight
Until it becometh well and tanned.
Surely good health shall follow me
All the days of my life,
And I shall dwell in happiness
And contentment forever.

Martha F. Roth in the *Journal of Outdoor LIFE.*

RECENT HOSPITAL DECISIONS

By DOROTHY KETCHAM, Ann Arbor, Mich.

Nurse Not Liable for Negligence

The Supreme Court of Indiana recently passed upon the liability of a charitable hospital for the negligence of a nurse. The appellee went to the hospital for an operation, agreeing to pay twenty dollars a week for room, nursing service, and other needs. It is alleged that while under the anesthetic a hot water bottle was placed against the patient's foot and that the foot and leg burned to such an extent that the leg had to be amputated to preserve life.

The hospital, since its organization in 1884, has been owned and operated "for the relief of the sick and destitute and in aid of benevolent and charitable purposes, and operated as a charitable institution." It has no capital stock, pays no dividends and is not operated for profit, the primary purpose for which it is maintained "is to render such gratuitous service to those who are destitute and unable to pay."

The court reviews diligently the cases relating to the negligence of a charitable hospital and, as a similar situation has not arisen in the state before, the court stated: "We believe that the rule that is sustained by the weight of authority or corporation is not liable to a beneficiary for an injury caused by the negligence of its employees if it has used due care in selecting such employees . . . The fact that the injured person was a pay patient is universally held not to render the institution liable . . . " The appellant was held not liable. *St Vincent's Hospital v. Stine, 144 N. E. 537.*

County Not Responsible for T. B. Hospital

Nellie Peck was employed at the tuberculosis hospital of Bristol county which hospital was established according to statutory provision. While working at a mangle in the hospital she injured her hand. The question which was before the Massachusetts Supreme Court, December, 1924, involved the liability of the county for such injury.

The employee's pay check came from the hospital, the doctor who first attended her was paid by the trustees of the Bristol County Tuberculosis Hospital. The county treasurer testified that he was treasurer of the hospital, but that this was a separate office. The funds for the hospital are borrowed and turned over, the money being raised from all the cities and towns in the county, except New Bedford and Fall River which have their own hospitals. The treasurer sends his checks to the superintendent of the hospital who is appointed by the trustees.

Patients outside the county are received at a stipulated fee. Deficits are made up by assessing the towns and cities in the "district." It is further pointed out that the trustees had not accepted the Workmen's Compensation Act. The superintendent testified that his appointment was made by the hospital trustees and that he had been secretary to the trustees since their organization. Three county commissioners were present at the first meeting to organize the trustees. Then, too, application for admission to the hospital is made through the local boards of health of the county, payment being made by the town treasurers with checks to the hospital treasurer.

It seems that in 1913 the county of Bristol accepted *Sp. Acts 1913 c. 807* which provide for the payment of compensation to laborers, workmen and mechanics. The act which provides for the establishment of tuberculosis hospitals (*St. 1916 c. 286*) is entitled, "An act to provide for the construction by counties of tuberculosis hospitals for cities and towns having less than 50,000 inhabitants." The county commissioners of each county except Barnstable, Hampshire, Nantucket and Dukes were required to provide adequate hospital care for all tuberculous persons who reside in towns with less than 50,000 population within their boundaries. (*G. L. c. 111, sec. 78.*)

The responsibility for acquiring the land as well as for constructing and maintaining the buildings is in the hands of the county commissioners. For this purpose they are authorized to raise and spend money, borrow on the credit of the county, issue notes signed by the county treasurer, and counter-signed by the county commissioners. The act provides further that the county commissioners are to be the hospital trustees making suitable regulations for its government appointing officers, etc. "It appears from these statutory provisions that the entire cost of the hospital, completed and equipped, as well as the annual cost for the care, maintenance and repair of the hospital, is to be paid by the towns liable.

"The towns thus liable in Bristol county are all the municipalities in said county excepting the cities of New Bedford and Fall River."

"The legislative intention, as gathered from this statute of 1924, indicates that when some of the cities and towns in a county support a tuberculosis hospital established under *St. 1916, c. 286*, they comprise a hospital district, and that even though all the cities and towns are included, this area, limited only by county lines, is still a tuberculosis hospital district. If the conclusion were reached that the claimant was an employee of Bristol county, the whole county, including Fall River and New Bedford which have hospitals of their own and are exempt from the benefit and burdens of the statute of 1916, would be obliged to contribute to the compensation awarded under the Workmen's Compensation Act. The evident purpose and intention of the legislature in making provision for the establishment of tuberculosis hospital districts as separate entities to be managed by county commissioners of their respective counties as trustees. The claimant was employed by the county commissioners acting as trustees for a hospital district . . . and was not an employee of the county of Bristol." *Peck's case 145, N. E. 582.*

Educators know that there is adventure in industry, but they believe that the adventure is the rare property of a few. They believe this so finally that they surrender this great field of experience with its priceless educational content without reserving the right of such experience even for youth. They know, as we all do, that industrial problems carry those who participate in their solution into pure and applied science; into the market of raw materials and finished products; into the search for unconquered wealth. They know that the marketing of goods is an extensive experience in the world of men and desires. They are not alone in their lack of courage to admit that limiting this experience perverts normal desires and creates false ones.—*Marot—"The Creative Impulse in Industry."*

Crime and punishment grow out of one stem. Punishment is a fruit that unsuspected ripens within the flower of the pleasure which concealed it. Cause and effect, means and ends, seed and fruit, cannot be severed; for the effect already blooms in the cause, the end preexists in the means, the fruit in the seed.—*Emerson.*

AN OUTLINE FOR INTERN EDUCATION IN HOSPITALS

By W. L. BABCOCK, M.D., Director, The Grace Hospital, Detroit, Michigan

AFTER a thorough study of plans for practical intern education in several hospitals, the Grace Hospital, Detroit, Mich., has worked out the following outline:

(a) *Surgical clinics:* possible in surgery, orthopedics, urology and all the surgical specialties.

(b) *Special treatment clinics and demonstrations:* possible in aspirations, transfusions and serum administrations, together with a great variety of other practical therapeutic methods (physiotherapy).

(c) *Clinical conferences:* given over to discussion of the various phases of diagnoses, symptoms, treatment and case progress.

(d) *Demonstrations of new methods:* new applications and discussion of new theories.

(e) *Bedside instruction:* individual instruction, which gradually prepares the intern for the assumption of a part of the care and treatment of a staff case. This is not to be developed except in the case of senior interns where aptitude and qualifications permit.

(f) *Systematic instruction:* covering one to six hours of demonstrations, between the hours of five and six p. m., two and three days each week. The subjects taught during class hours can be arranged as a symposium and the various angles covered in successive meetings. For example:

Three to six hours to cover the whole subject of diabetes, each phase of diagnosis and treatment to be illustrated with weight, blood and sugar charts of patients previously under treatment, together with demonstrations of dietary feedings.

(g) *Instruction in keeping records:* Interns are not going to keep good records, from which they can learn much, unless they are first instructed and then made to follow the outlines of a complete and adequate chart or record of a case. It is the responsibility of the member of the attending medical staff in charge of the staff or private patient, to see that the intern on the case completes his full, required chart outline. It is necessary that the attending physician or surgeon consider this a personal and individual responsibility. Members of the attending staff would be greatly relieved of much detail in this connection if they developed a proper standard or maximum level of record work and insisted that each intern keep his record up to that standard.

(h) *Clinical staff meetings monthly:* The resident interns should be invited to attend the clinical attending staff meetings. Attendance should be obligatory, subject to proper excuse. It would be desirable to base the programs for these meetings on clinical cases in the hospital, partly for the educational value to interns of the study of patients seen by them in the service and partly for the reason that our clinical material here offers abundant opportunity for review. It is further suggested that these staff programs be grouped generally under departments and that the chief of the department or division be made responsible for the program and discussers. These staff department symposiums should bring into the reviews and discussions all services concerned in the treatment of the patient, such as the x-ray, laboratory and specialties. The program for the monthly staff meetings should be arranged at least five or six months in advance so that the chiefs of departments charged with the program can arrange for their review of patients and present the proper clinical material. It is further recommended that leading specialists or noted medical men from out of town be invited to address the staff, at least at two meetings each year.

(i) *Autopsies:* Autopsies are a great educational factor and are one of the prime requisites in intern education. The attending physician is the greatest influence in obtaining legal consent to an examination of the remains of his deceased patients. The healthy growth of the number of autopsies each year is a matter of congratulation although the percentage of total deaths autopsied is still far too low.

The above schedule is in addition to regular assignments to services in the rotating service schedule. Through this schedule the interns spend three months in general surgery and surgical specialties, three months in medicine, dermatology and other medical specialties, three months in obstetrics and three months in laboratory work and clinical laboratory diagnosis. In connection with the rotating schedule, assignment is made to definite services for the purpose of keeping up the records of these services.

(j) *Out-patient department:* Assignment to out-patient department service for two hours daily for sixty to ninety days.

FREE CITY-WIDE EXAMINATION TO BE GIVEN 6,000 N. Y. CHILDREN

More than 6,000 children registered for clubs and house activities at the Educational Alliance, New York City, will receive free examination at the Beth Israel Hospital Dispensary under the supervision of the Health Committee among Jews. This is the largest group examination yet planned by the committee. Although nine physicians including three women for the examination of young girls and women have volunteered their services at the clinics to be held Monday, Tuesday, Wednesday, and Thursday afternoons. It is expected that it will require a year to complete the examinations. Wherever a serious condition is found, parents will be advised how to proceed.

THE HUMAN TOUCH

The people who enter our hospitals are for the most part very sensitive and are apt to judge the person wrongly who does not show them a little kindness. A harsh word or any sign of a hasty temper from one of the officials does a great deal of harm to the institution, for the injured party is not slow to make it known to others. On the other hand, if a patient on coming to the hospital is received in a kindly and sympathetic manner, it is never forgotten and they are only too proud to ring its praises. It is, therefore, of vital importance that, before electing anyone to serve the hospital, no matter in what capacity, it should be ascertained after their other qualifications are found to be satisfactory, whether such persons possess the human touch."—Frank I. Hancock, superintendent, West Bromich Hospital, England.

"Glory of warrior, glory of orator, glory of song,
Paid with a voice flying by, to be lost on an endless sea—
Glory of virtue, to fight, to struggle, to right the wrong—
Nay, but she aimed not at glory, no lover of glory she;
Give her the glory of going on and still to be."—*Tennyson.*

SURGICAL DRESSING TECHNIQUE OF ST. AGNES HOSPITAL, PHILADELPHIA, PA.

By JAMES K. McSHANE, St. Agnes Hospital, Philadelphia, Pa.

BY USE of metal receptacles containing the gauze, cotton and towels, a great improvement is made in the usual technic of dressing surgical cases. The drums for this purpose, made by Lentz, are of two sizes. The large size for the gauze and towels has a hinged lid so that it may be opened aseptically, the material desired removed by means of a sterile instrument and the lid closed again without contamination of the contents. The small size has a removable lid and is used to hold the pledgets of cotton.

Figure 1, illustrating the general arrangement of the dressing carriage, shows the drums in place. It contains the usual array of antiseptics; green soap and alcohol sponges are to be seen in the right hand corner; two trays of instruments in the central part; two hemostats, with all except their handles immersed in phenol 1:20, on the left hand side, and the before mentioned drums, containing the gauze, cotton and towels, in the foreground.

This carriage is wheeled alongside the patient's bed, the surgeon wearing gown and gloves, the latter only if he wishes, as all manipulations are carried out by means of sterile instruments so that the hand never enters the wound. The nurse removes the outer dressings and then, by means of a sterile hemostat which she has taken from the phenol solution, hands the surgeon whatever sterile instrument he desires, as is shown in figure 2. With these instruments the surgeon then removes the inner dressing from the wound and drapes it with sterile towels which he receives from the nurse, who has removed them from the drum by means of her sterile instrument, as is shown in figure 3.

Method Saves Time

It is readily seen that this measure is accomplished quickly and with absolute asepsis, so that the towels remaining in the drum are perfectly sterile. The surgeon is now prepared to cleanse the wound and for this purpose he receives successively green soap, alcohol and dry cotton sponges. These steps are shown in figure 4, the dry cotton being handled from the container just as the illustration shows the alcohol sponges being manipulated. Note that all these steps are being carried out by means of instruments and that the hands do not touch any of the materials or the wound. If it is necessary, the wound may now be irrigated. Dakin's tubes may be changed if they are in the wound, or whatever other steps that are deemed necessary may be carried out. When the wound is in a satisfactory condition, the surgeon can discard his instrument, if the case is an infected one, and receive others that are sterile. He is now ready to receive the gauze which is given to him in the manner shown in figure 5. Here it will be noted that the nurse removes the gauze from the drum with her instrument and hands

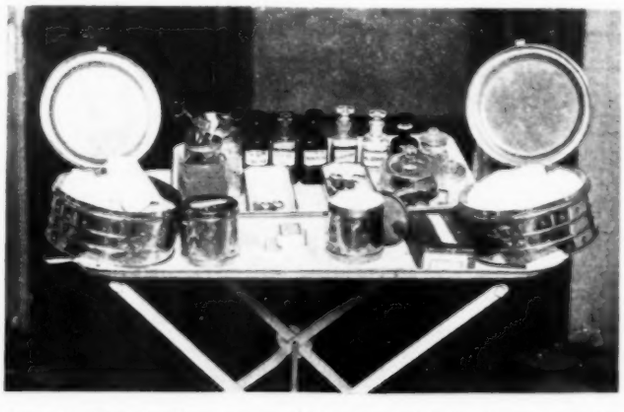


Figure 1. The dressing tray ready for use with the drums in place.

Figure 2. The first step of the dressing. The nurse handles the instruments with her sterile hemostat.

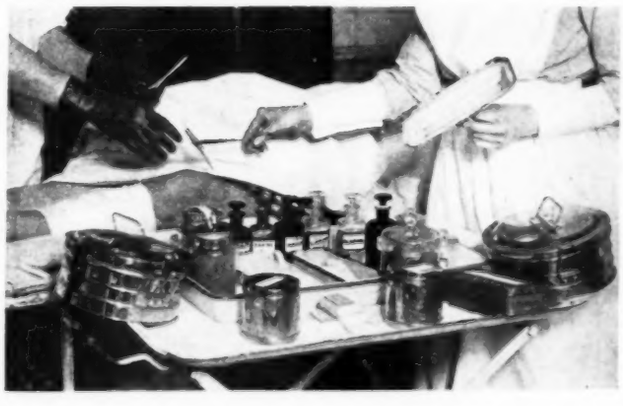


Figure 3. The towels are removed from the drum by means of sterile instruments.

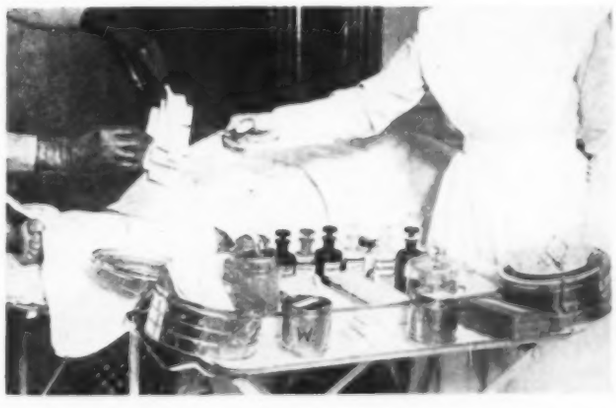


Figure 4. Dry cotton is handled from the drum in the same manner as the alcohol sponge pictured above.

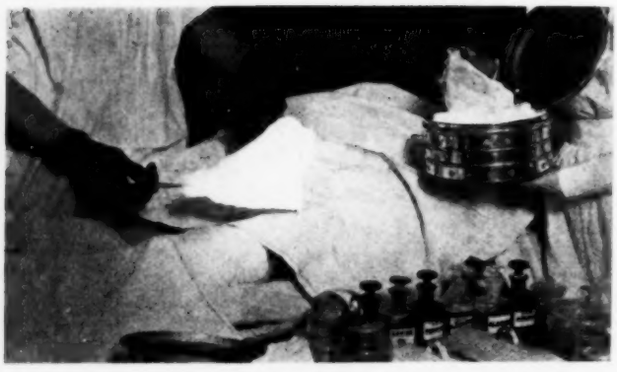


Figure 5. Perfect sterility of the drum contents is maintained by the above technique.

Figure 6. The cotton is rolled into balls and placed in the drum.

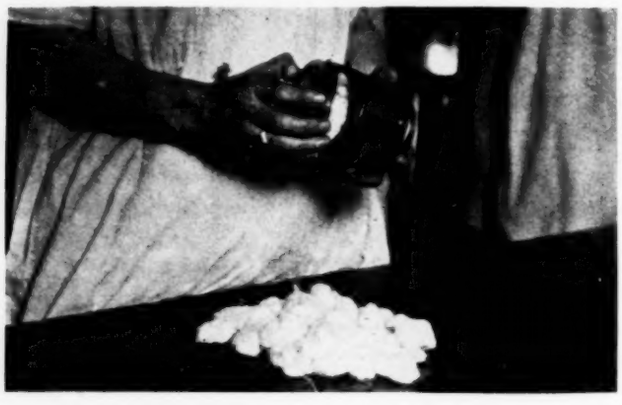


Figure 7. Placing the lid on the drum.

Figure 8. The gauze is cut by machine and the drum loaded.

it to the surgeon. As soon as he has received as much as he requires the lid of the drum is closed so that the remaining gauze is sterile. As soon as the nurse returns her sterile hemostat to the phenol solution, the dressing is finished and the carriage is wheeled to the next patient.

The remaining illustrations show how easily and quickly the loading of these drums is accomplished. In figures 6 and 7 it will be noted that it is only necessary to roll the cotton into pledgets, place these in the can and put the lid on. Figure 8 shows the gauze being cut into the proper sizes, by means of a machine, and placed in the drum, which is then ready for sterilization.

Advantages of Method Using Drums

The advantages of this dressing technic with the use of the drums are as follows:

1. Maximum sterility.

A. The drums can be placed in the autoclave, thereby insuring the absolute sterility of the contents.

B. The patient is better protected, for with the technic outlined there is no danger that he will be exposed to unsterile materials. The same cannot be said when other makeshift methods of handling the materials are employed. The surgeon and nurse are also fully protected from infection.

C. The degree of sterility in a series of dressings is far greater with the use of these drums than it is with packages of dressing materials.

D. A higher plane of asepsis is maintained by all who come in contact with the dressing tray.

2. Minimum waste of time.

A. A sufficient number of these drums can be secured to supply the entire hospital and they can all be loaded and sterilized at one time.

B. The dressing speed, a factor of importance where a large number of daily dressings must be made, is greatly increased, as the time required by the nurse in handling these drums is less than that required in opening the packages of gauze, cotton and towels. Besides, there is no time lost between dressings and a large series can be made without interruption.

C. Dressings can be made at any time on very short notice, as sterile materials are always available.

3. Minimum waste of material.

A. The surgeon is given just the amount of material that he requires for a dressing. With the package method the entire package must be used at one dressing, or the unused portion discarded as contaminated.

B. As the containers are metal they are very durable, will stand hard usage, and will last a long time.

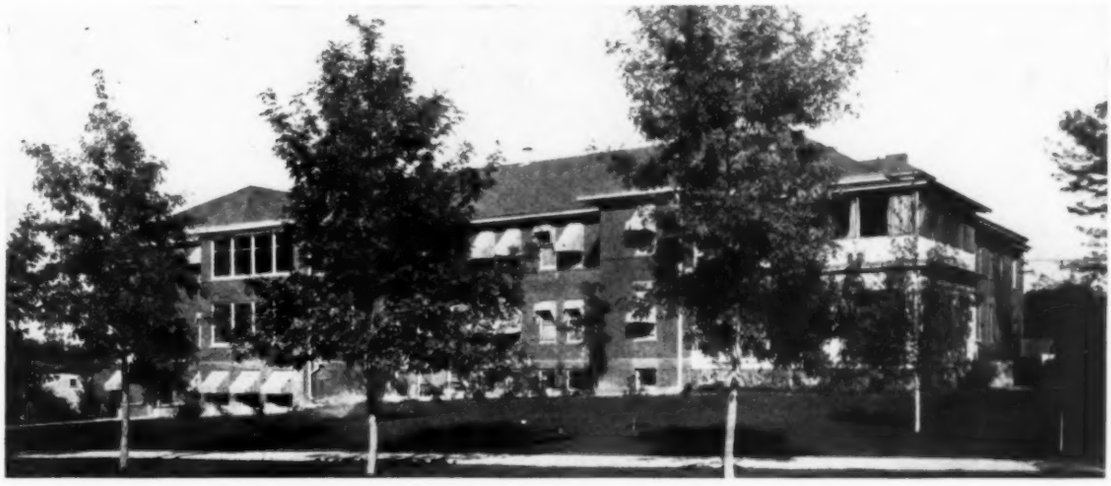
NATIONAL TUBERCULOSIS ASSOCIATION PUBLISHES TECHNICAL SERIES

The executive office of the National Tuberculosis Association is publishing a new technical series, Number 1 of which is just off press. Number 1 is entitled "Natural and Artificial Cure of Tuberculosis," by Dr. William Charles White. The contents of this bulletin was originally presented as a paper before the annual meeting of the New Jersey Tuberculosis League.

Other numbers of the series will include such topics as selecting a site for a tuberculosis sanatorium with some remarks on plot plans; housing of the tuberculous insane; suggestions for making a case-finding survey; fundamentals of tuberculosis work; diagnostic standards, and many other vital subjects pertaining to tuberculosis.

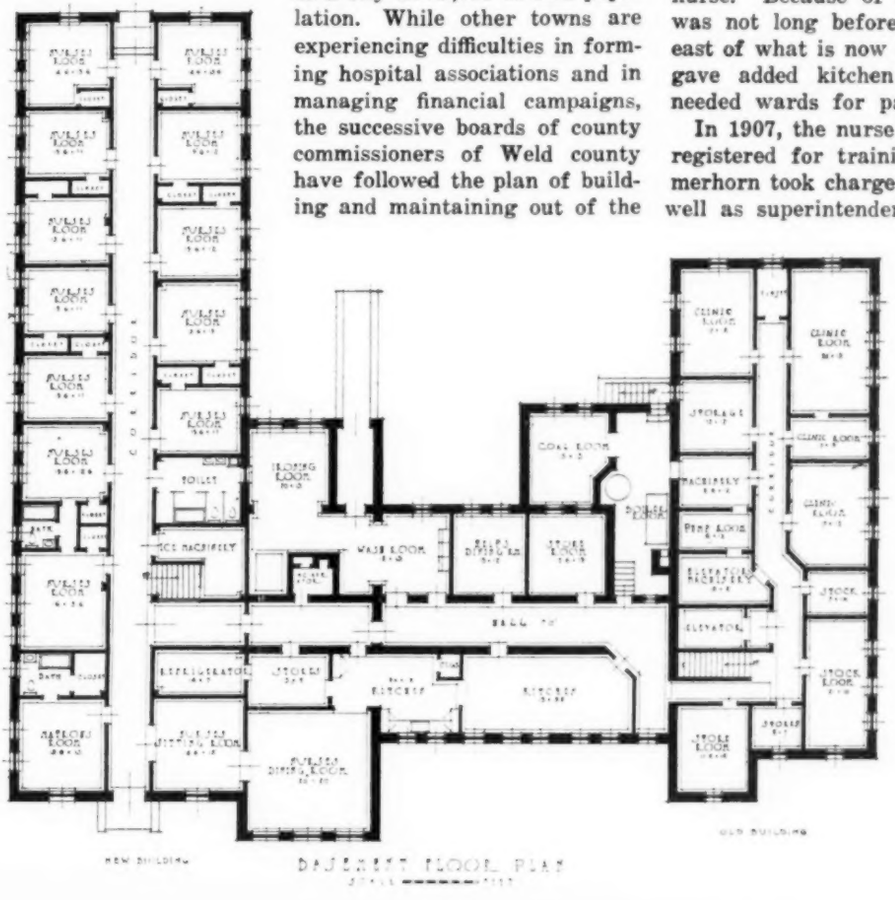
WELD COUNTY BUILDS IDEAL MODERN HOSPITAL IN GREELEY, COLO.

By VERNON McKELVEY, Business Manager, Greeley, Colo.



Weld County Hospital, Greeley, Colo.

WITH the increased facilities and modern conveniences made possible through the recent addition to Greeley Hospital, Greeley, Colo., the sick citizens of Weld county are well accommodated. Built and principally equipped out of the county funds, this hospital is conceded to be one of the most up-to-date institutions to be found any where in the United States in a city of 15,000 or less population. While other towns are experiencing difficulties in forming hospital associations and in managing financial campaigns, the successive boards of county commissioners of Weld county have followed the plan of building and maintaining out of the county funds a general hospital for the use of all classes of patients.



BASEMENT FLOOR PLAN

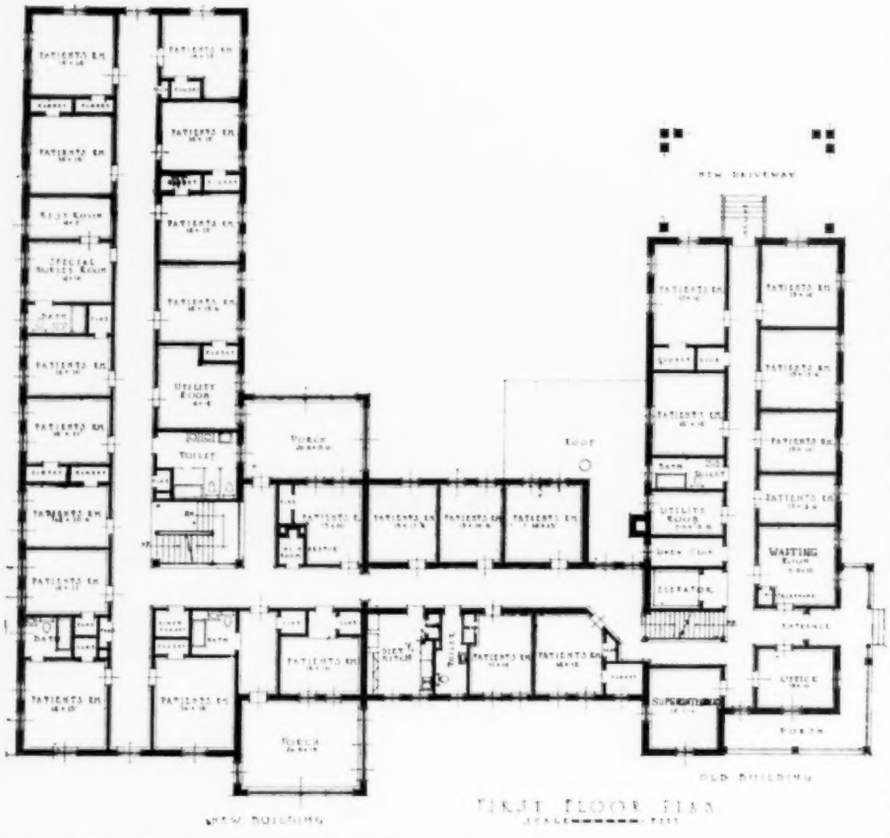
Opened in 1904

The original hospital building was opened by the board of county commissioners in January 1904, under the immediate supervision of Miss Hattie Weaver, a trained nurse. Because of the steady increase in patronage it was not long before an addition had to be built to the east of what is now the oldest part of the hospital, which gave added kitchen facilities, an operating room and needed wards for patients.

In 1907, the nurse school was opened with six students registered for training. In 1911, Miss Mary L. Schermerhorn took charge as superintendent of the hospital, as well as superintendent of the school, which position she now holds. Like the hospital, the training school has grown to an enrollment of eighteen students.

In January 1915, what is now the connecting link between the original building and its newest addition was opened to the public, but again, because of the city and county growth, the quarters became inadequate to provide for the growing number of patients, so that plans were drawn and the contract awarded for the latest addition.

It was the desire of the county commissioners and the superintendent to have a building containing additional nurses' quarters with rooms for the help as well as more rooms for the patients. Also, it was their wish to have a modern building in every respect. In solving the problem, the nurses' rooms were



placed on the ground floor of the new building, because, as the ground slopes toward the new addition, the nurses' quarters are above the grade. The main floor contains private rooms for patients, some with private baths, utility and toilet rooms, and quarters for special nurses.

The Greeley Hospital is located on an elevation in the heart of the city, which makes it very accessible for those who frequently visit the sick. Water coming from the snow-capped peaks of the Rockies furnishes the patients with a good pure supply of mountain water, which is cooled through the refrigerating system of the hospital. The hospital is equipped with a refrigerating plant that not only makes enough ice for the institution, but refrigerates a room for the storage of meat, vegetables and fruit.

Through a silent call system, which is connected with every patient room in the building, the patient is assured the best service that can possibly be rendered so far as the nursing staff is concerned.

On each floor is located a utility kitchen where the nurses may get trays from the main diet kitchen in the basement by the dumb waiter, telephone their wants to the kitchen, prepare light meals and meet the emergency needs of their patients. Each floor also has an incinerator for the burning of all trash. There are also utility rooms on each floor equipped with the most modern bedpan washers, racks, slop sinks, and other equipment.

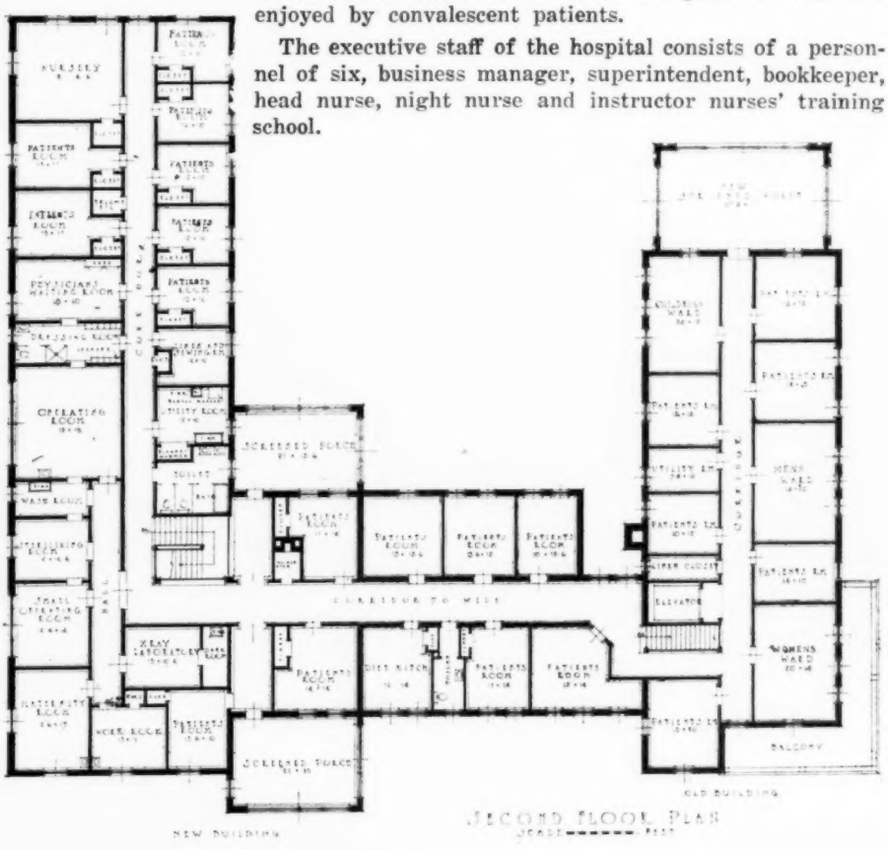
The patients' rooms are neatly furnished with modern hospital beds and nurse cots that extend under the beds when not in use. The floors are of a composition material in buff color, with sanitary bases. The halls are furnished with cork-linoleum. The doors are one panel of smooth finish in mahogany color. A number of the best appointed rooms, and a splendid x-ray equipment have been furnished by citizens of Greeley and Weld county. The large number of donations is evidence of the interest taken in the hospital by Weld county citizens.

Near the heating plant is the laundry with its 50-sheet washer, an extractor, mangle and drying room. Clothes chutes lead from each floor to the laundry.

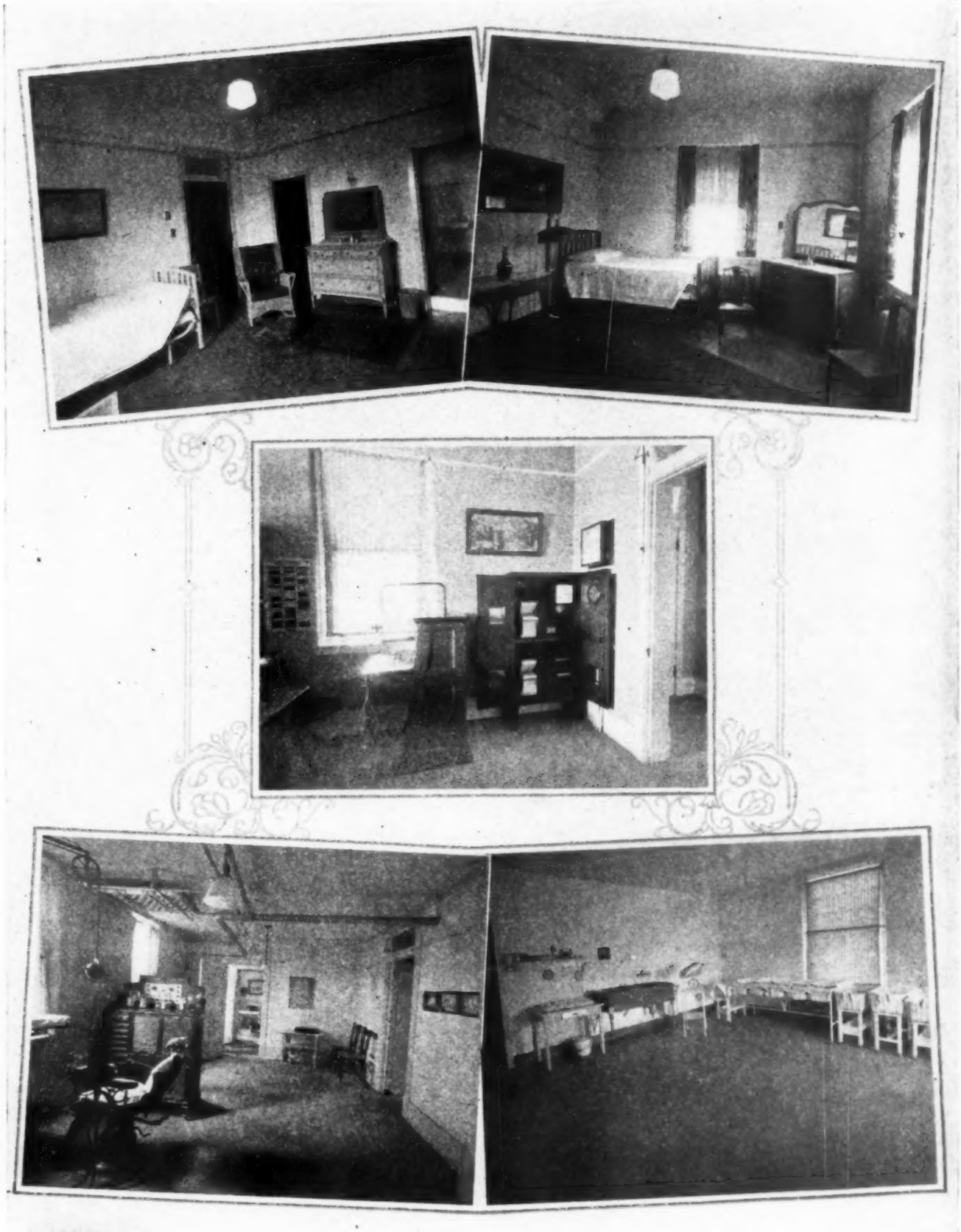
Five rooms in the basement are set aside for the use of the Weld County Clinic, where the poor who cannot afford to pay for medical advice come once a week.

On the second floor will be found the new laboratory, two operating rooms, sterilizing room, scrub-up room and x-ray room, besides the nursery, three wards and patient rooms. There are also five sun porches which are enjoyed by convalescent patients.

The executive staff of the hospital consists of a personnel of six, business manager, superintendent, bookkeeper, head nurse, night nurse and instructor nurses' training school.



INTERIOR VIEWS OF WELD COUNTY HOSPITAL



(Upper left) private room showing bath adjoining: (upper right) a cor ner of private room; (center) corner of waiting room showing information desk; (lower left) a scene in the dental department; (lower right) a view of the nursery.

FIRST CLASS OF JUNIOR AIDS GRADUATED FROM ARMY MEDICAL CENTER

The graduation exercises of the first class of junior aids completing the training course in occupational therapy at the Walter Reed General Hospital, Washington, D. C., were held at the hospital at 3 o'clock Friday afternoon, March 27.

Major George F. Lull, M.C., director of occupational therapy, gave a short introduction, followed by an address by Lt. Col. A. C. Monahan, sanitary officer, Reserve Corps, and Major General Merritte W. Ireland, Surgeon General, U. S. Army, presented the certificates. An informal tea completed the program.

The graduates were Miss Frances Johnson, Milton, Mass.; Miss Carolyn Jones, Bethlehem, Pa.; Miss Doris Wilkins, Carlisle, Mass.; Miss Rita Ferne Woodman, Wolfeville, Nova Scotia, Can. All of these graduates have been appointed to serve in military hospitals.

The army hospital training course covers a period of six months, and includes both theoretical and practical work. In the shops which are adequately equipped, opportunity is given the student to gain greater proficiency in chosen lines of work, such as the special phases of the different crafts. At the same time, instruction covers the theory of each subject as used for curative, diversional, reeducational and vocational purposes.

The theory and general principles of weaving, types of looms and their operation, designing and blocking patterns from draft, color combinations and materials and dyeing are given in the shop for weaving. Instruction, theoretical and practical, familiarizes the student with the various processes of building and decorating pottery, with mould and glaze making, and with the care of, stacking and firing the kiln. In the woodworking shop, demonstrations and practice are given with special tools and machines used for curative exercises. Instruction is given in the use and care of tools and equipment, types and qualities of wood and lumber, and proper selections for specific purposes and appropriate articles to be made of wood. Practical work includes wood carving, wood turning, and construction. The general principles of reed and cane work are demonstrated. Opportunity is given for obtaining practical experience in making articles involving construction of an advanced type. Kinds and quality of equipment and raw material are considered. In the jewelry and metal workshop, practical work is given with various metals such as copper, brass, pewter, silver, and gold, involving processes in sawing, filing, soldering, stone setting, raising, annealing, cleaning, polishing, coloring, plating by electrolysis, enameling, etching, and repoussé work. Instruction is given in the theory and practice of design and color, and their importance in, and application to, the crafts. Theoretical and practical work in plant propagation and garden planning give the student the appreciation and knowledge of flower gardening that will enable her to interest patients and direct their activities therein. In the course covering supplies and equipment, instruction is given in procurement, care, distribution, and accountabiltiy, cost and care of minimum amounts of material necessary for various types of work, and methods of disposition of finished products. Instruction is also given in the correlation of the work of the educational department and the social service section.

Lectures by officers on the staff of the hospital furnish such supplementary instruction in anatomy, physiology, medicine, surgery and hospital administration as is deemed essential in familiarizing the occupational therapy aid with the principles involved in her work.

The second training course, limited to ten students, will begin October 1, 1925. Applicants must be not less than twenty or more than thirty years of age. They must be graduates of accredited schools of occupational therapy, and in addition are required to have credits for at least one year of college or special training, such as fine and applied art, social service, playground work, advanced academic or commercial work.

RAPID ADVANCE IN HOSPITALIZATION FOR WAR VETERANS

The development of hospitalization of war veterans can, to some degree, be measured by the rapid growth of the U. S. Veterans' Bureau work. At present the bureau is operating forty-nine hospitals, seventy-four dispensaries, ninety-four clinical laboratories, and about 100 x-ray laboratories, and is housing over 29,000 patients.

In the appropriations recently made available by Congress six new hospitals and national training schools for the blind are provided for, and funds are made available for the completion of another hospital now partially constructed.

That the bureau is emphasizing the rehabilitative aspect in the treatment of veterans is shown by the work it is undertaking to restore the patient to economic independence, rather than just to maintain him in a hospital and pay his compensation. In many of the hospitals the men find much pleasure and healthful exercise in planting and tending of truck and flower gardens. Various other forms of occupational therapy are being developed.

AMERICAN WOMEN ASKED TO ENDOW BEDS IN LONDON HOSPITALS

The American Woman's Club of London, England, has launched a project for endowing twelve beds in the George Washington ward of the Royal Free Hospital of London, according to the recent announcement of the joint committee in charge of raising the funds. One bed has already been endowed and named for Dr. Elizabeth Blackwell, the pioneer woman physician of the United States.

Dr. May Thorne, distinguished English surgeon and governor of the Royal Free Hospital, of London, who is now touring the United States in the interests of the endowment of the twelve beds, was a close friend of Florence Nightingale during the latter years of her life.

HOSPITAL LIBRARIES ON INCREASE

That the medical library is becoming an essential feature of an increasing number of hospitals is shown by the records of hospitals which have been approved for internships by the Council on Medical Education of the American Medical Association. At present 77 per cent of all the hospitals approved have medical libraries whereas in 1914 only 40.7 per cent had them. Interest in medical libraries also is indicated by the large number of hospitals which are seeking information on how to start and organize a library for the attending staff and interns.

The interest in health today is very great. In proportion to its importance and in relation to past appreciations health is not overvalued. But we should be careful not to appraise it too highly as an isolated value. Oftentimes we make it too prominent as an end; then it protrudes too much; and mars the whole of life. To recognize that it is of meaning and significance only in its relation to other values is tremendously important today. —*Williams.*

OPENING DAY AT ALLIANCE CITY HOSPITAL

By FRED WALKER, Superintendent, Alliance City Hospital, Alliance, Ohio.

ALLIANCE City Hospital, Alliance, Ohio, has graduated into the one hundred bed class. With the recent completion of a large addition to the original building, space has been provided for forty new beds in private rooms and wards, new operating rooms, laboratory suite, x-ray department, and library. This has made possible a very satisfactory rearrangement of the entire hospital. The new children's department in the southeast wing of the first floor with service independent of the rest of the hospital, has been furnished by the Alliance Rotary Club. The medical library and consultation room have been made attractive by suitable furniture.

At this stage of progress we felt that an opening day should be observed which would give to the people of the city and community a special opportunity to inspect the hospital with its late addition and improvements. The date was selected for the occasion, and the announcement given to the local newspaper. Following its original announcement of the opening date, the newspaper ran a series of large front-page photographs of the hospital exterior, south operating room, nursery, children's ward, play room, and solarium. In connection with these photographs our stories giving detailed descriptions of the equipment, service, and administration of certain departments, were printed.

At a meeting of the city council we invited all councilmen and city officials to attend our opening as guests of honor. Rotarians were also invited to be present as special guests because of the interest which prompted their organization to sponsor our new children's department. The mayor of the city addressed a newspaper communication to all citizens of the community in which he pleaded for support of the municipal hospital in which public money was being invested, and urged that everyone make a personal inspection upon opening day.

In the meantime the features of our formal program were being planned. By special permission the last summer concert of the city band was scheduled for the evening of our opening day upon the lawn of the nurses' home, adjacent to the hospital. Three local banks offered savings accounts of one dollar to each child who should participate in our special juvenile attractions—baby show, kiddie-kar race, or doll carriage parade, respectively. In addition to the savings account which each participant would receive, suitable prizes for the winners in each event were donated by local merchants. Prominent women of the city consented to act as judges.

As souvenirs for each family represented at the opening, attractive booklets, descriptive of the hospital, were prepared at a cost of about one hundred dollars per thousand. These were forty-page booklets, profusely illustrated, to give a clear description of all departments. The first section included a preface, historical sketches, directory of staff physicians, and roster of officers of government and administration. The body of the book was devoted to outlines of service rendered in the various departments. The last pages were reserved for complete information in regard to our training school, and closed with a revised roll of the alumnae of the institution. We intended that these books should cultivate an appreciation of our hospital through definite knowledge of its up-to-date equipment and methods of work, and in this way serve to combat the inevitable false impressions which have no basis in real fact. The entire cost of this souvenir booklet feature was borne by special friends, and was not in any way included in our institutional accounting.

Front view of Alliance City Hospital.

Upon the eve of the opening day our newspaper published a complete program of our exercises, including special program for the band concert. It also ran photographs of the mayor of the city and the superintendent of the hospital, who would officially receive all visitors at the hospital upon the morrow.

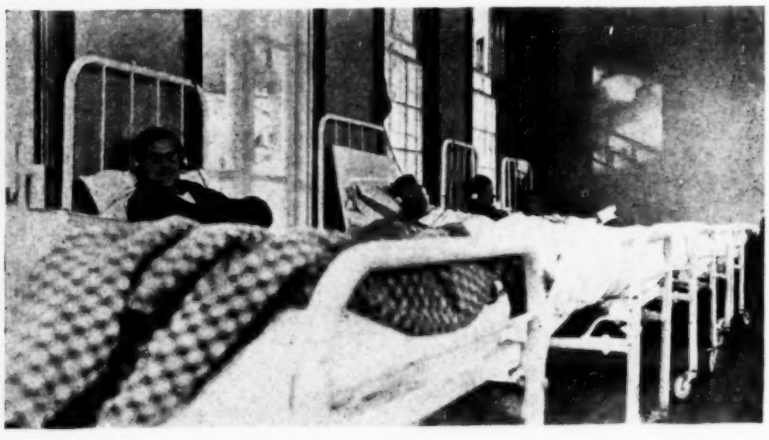
The appointed day was beautiful. By one o'clock a

(*Continued on page 557*)

RADIO IN THE NORTH READING STATE SANATORIUM FOR TUBERCULOSIS

By J. ELLIS DOUCETTE, Steward, North Reading State Sanatorium for Tuberculosis, North Reading, Mass.

BEFORE the introduction of radio at the North Reading State Sanatorium, North Reading, Pa., entertainment for the ward patients had always constituted a difficult problem. The ambulatory patients have access to the assembly hall where movies are shown and where a piano or organ is always available, but as the wards are somewhat divided up, it has always been difficult to attempt satisfactorily concerts or similar forms of entertainment for ward patients. A portable piano is practically out of the question. The same thing is true of a stationary piano in each ward, as the temperature changes that occur daily in a ward for the tuberculous would very soon ruin any instrument of this kind. We have had some satisfaction from a small portable organ but many musicians whom we were able to obtain objected to this instrument, and the ward patients, therefore were somewhat neglected in the matter of entertainment.



A portion of a ward showing bed patients enjoying their earphones.

Other Auditory Entertainment Insufficient

The phonograph has helped the situation somewhat, but interest in that instrument is largely dependent on the amount of money available for new records. Granted that new records are frequently purchased everyone knows the effect of half a dozen phonographs playing together each within earshot of the other. Moving pictures shown with proper equipment and with a certain amount of theatrical atmosphere are very satisfactory, but the small portable instruments that are set up and used in a temporary manner are far from satisfactory.

When radio began to show signs of development it occurred to us that it might be a means of helping us with our ward entertainment problem. In the spring of 1923, after considerable deliberation and investigation, a committee appointed to represent the patient body decided to buy and install some kind of radio apparatus. Some of the mechanically inclined patients had built up a set, but the results obtained were not wholly successful. The question then came up of the kind of set to buy. We felt that it should be portable and still be powerful enough to be heard at some distance. With the limited amount of money available and the uncertainty of obtaining apparatus suitable for our needs at that time, this question was not easily answered.

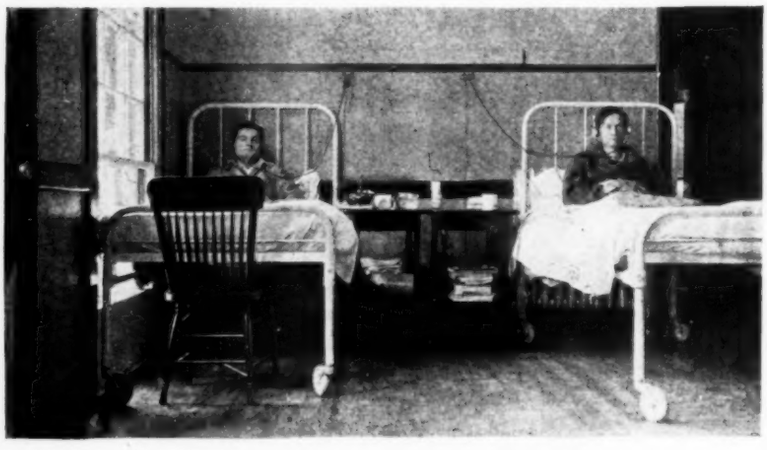
Type of Radio Installed

We finally decided on a Federal No. 57 receiving set which consisted of one stage of radio frequency amplification, a detector, and two stages of audio frequency amplification, four tubes in all. In addition to this receiving set we purchased a loud speaker, all the necessary tubes, batteries, including a storage A battery, and one pair of earphones. The whole outfit together with some antenna wire and accessories cost us about $170.

A separate antenna and ground were first installed in each building in which we wished to use the set, and the outfit was moved from place to place and tested. As we did not seem to get volume enough on the loud speaker we added a one stage power amplifier with another tube and this boosted the output considerably. The quality, however, was rather poor and the results so uncertain that we were not furnished much real entertainment and our project, while not exactly a joke, was very often a pronounced failure.

Through the summer of 1923 we continued our experimenting with different aerials, and when the cool, fall weather came the results obtained were somewhat better. Quality of reception had improved a great deal and volume at times was so great that many of the sicker patients were disturbed, and we were forced to do away with the loud speaker.

About the middle of November we consulted a telephone company of Reading and, with the advice of their experts, decided to locate our set permanently and run wires from it to earphones at each bed in the wards, making in all a total of sixty-two. At that time we were able to purchase only forty-two headsets, but were able to wire up



A corner of the receiving ward showing the method of wiring for the earphones.

to all of the beds. This proved to be a more satisfactory arrangement and soon we began to see more smiles and hear less groans while the radio was turned on. During the month of Nov., 1924, we were able to purchase twenty more pairs of head phones which complete the service to the hospital ward patients. I might state that all of our phones have proved very satisfactory, as they are light, sensitive, and have a good tone quality.

A close-up of a receiving set showing a patient operating a monitor phone so connected that he hears the signals as they are heard through the earphones.

Certain of the men patients were appointed to operate the set during fixed periods and soon the radio began to be appreciated more and more by the shut-ins who must remain in bed. I might state here as a matter of interest to radio "fans" that we reconstructed our Federal set. We eliminated the single stage of radio frequency amplification and changed the set to a single circuit regenerative one. This change has resulted in our having to maintain one tube less and still be able to get greater distance, more volume and clarity and much greater ease in tuning.

The opening up of the new powerful WEEI in Boston has helped to make our system more enjoyable, as the programs from this station are always good and we are near enough to it to make reception very easy. On the other hand, we are far enough away easily to tune it out. Station WNAC in Boston, is another excellent local station, and atmospheric conditions are very bad indeed when we cannot reach either of these stations.

As mentioned before, we use a storage A battery, and part of our B battery system is of the storage type. As our local electric current is direct, we have no difficulty whatever in charging these batteries. The A battery which requires frequent charging is set up permanently in the basement below the receiving set and the change from being charged to discharging through the set can be effected in a second by simply operating a double pole double throw switch. At present our system is in almost constant use every afternoon and evening until nine o'clock, receiving music, speeches, political events, sporting events from many parts of the country.

Aside from the purely recreational point of view, the physicians at the sanatorium are pleased to find the radio is of direct therapeutic value. The fact that a patient can be resting comfortably in bed while being entertained is very important. The radio aids the tuberculous patient to get the much needed rest which becomes less distasteful when this medium of entertainment is available. His mind is taken up to such an extent that he is less apt to spend hours brooding over or talking over his physical condition with his neighbor.

The upkeep of the apparatus is practically all taken care of by certain of the patients who are physically and mechanically able to do so under the supervision of the steward. These men also derive much benefit from this work as it centers their attention on something inventive and offers a certain amount of physical exercise which is beneficial to them.

The question has come up recently as to whether we should install more sets or continue our present system to the other buildings. I feel that it is better practice to limit the number of receiving sets as much as possible, as there is apt to be more or less interference between separate receiving sets, and the hours of use can be better regulated from one unit. The matter of distribution of the energy received is a simple matter compared to the proper receiving of it.

However, I should like to see a separate receiver and loud speaker in our assembly hall in order to furnish music for the movies and the employees' dances which are held weekly through the winter months. At present we have to depend largely on a chance pianist, either a patient or employee, and the phonograph. I feel confident that radio will supply all the music we need for these events.

Radio has arrived. It is no passing fad but a real live agent which can be put to good use especially in a hospital or institution. Many people think that apparatus constructed one month is obsolete the next. Such, however, is not the case, as our outfit is built on one of the simplest and earliest principles of radio.

I would suggest that any hospital or institution which is in the process of construction and contemplating the installation of radio should have its wiring done during the construction period when other wiring is done. Double circuit jacks should be installed at each bedside so that if any patient does not care to listen in, by withdrawing the plug from his jack the connection will still be established for the others.

In conclusion, I wish to state that the radio has been a great help to us in keeping up the morale of the patients that were most difficult for us to reach with other forms of entertainment, namely, the ward patients.

ALLIANCE CITY HOSPITAL

(*Continued from page 555*)

steady stream of visitors was filing through the building, directed by student nurses who were instructed to make explanations and answer questions. The baby show, with about eighty hospital babies under two years, was the most popular special attraction, although hundreds enjoyed the contests upon the lawn and sidewalks. As visitors passed through the diet department they were served punch and wafers.

In the evening every member of the city council was present, together with officials of other municipal departments. The Rotary Club had postponed its regular weekly noon luncheon until evening in order that members and their families might enjoy the reception in the children's ward. The attendance at the outdoor band concert upon the lawn was the largest of the concert season. Automobiles were parked for several blocks upon the adjacent streets.

In reviewing the success of this event in the life of our hospital, we believe that we should pay honest tribute to our local newspaper for its unstinted support in giving publicity to our plans and programs. We attribute our success in this instance directly to a consistent series of newspaper articles.

We have no copyrights upon any of the ideas which we have used in this matter, and are glad to pass them on to any who may wish to grasp them.

THE INFORMATION DESK

PAINT AND VARNISH REMOVERS

The method of removing old paint, varnish and enamel by the process of burning it off has serious drawbacks in a hospital where the danger of fire is added to the disagreeable smell of the smoke caused by the process. These old coverings of wood or metal may be removed by using either of the preparations the formulae of which follow.

Flour	385 parts
Hydrochloric acid	450 parts
Chlorinated lime	160 parts
Oil of turpentine	5 parts

This mixture (have druggist mix it) is applied to the surface and left for some time. It is then brushed off and brings the paint away with it.

Sodium hydroxide	5 parts
Solution of sodium silicate	3 parts
Flour paste	6 parts
Water	4 parts

This worth of the formula lies in its decomposing the paint.

INITIAL STEP TOWARD CREATING GOOD IMPRESSION OF HOSPITAL

The information department is one of the most important parts of any hospital. There people form their opinion of the hospital, so that the publicity value of good service at this point cannot be overestimated. It is a time when anxious friends must feel a sympathetic interest exists. A hospital must deal with all types of people and in no department is it of greater importance to have people capable of understanding and of using the utmost tact. A super-abundance of courtesy must be used when unreasonable or foolish demands are made. This service which furnishes material with which folk sing the praises of the institution should begin at the information desk; and does.

The information clerk needs all the tact, cheer, grace and sympathetic good humor that any individual can have. She must be as wise as a serpent and harmless as a dove. Hers is one of the most important points of contact with the public that the hospital has. She may give cheer or she may burden already overloaded hearts. She sends folks away with bitterness towards the hospital or with the feeling that her helpful cooperation made the entire visit easy. Clerks who fail to understand the real service they may render are a liability a hospital can ill afford to carry; those who realize their opportunity, give the hospital a good name by the mere performance of their daily duties.

HOSPITAL ROUND TABLE

The following questions are a part of the "Hospital Round Table" series which is sent out monthly to hospital superintendents by THE MODERN HOSPITAL PUBLISHING COMPANY, INC., (See editorial, page 536.) For the convenience of readers a similar list of questions based on the text matter of the particular issue, will appear in these colufns of the magazine each month.

1. How should drugs be accounted for in the hospital? P. 501.
2. In preparing a budget, how can cooperation be secured from department heads? P. 502.
3. How should patients' clothing be cared for in a general hospital? P. 509.
4. What should be done with a patient's valuables during his hospital stay? P. 509.
5. How can the effect of annoying sounds from outside the hospital be minimized? PPs. 511 and 512.
6. What factors enter into overcoming noise nuisances in the hospital? PPs. 512 and 513.
7. Does the patient's death end the hospital's moral responsibility in the case? P. 516.
8. Are the criticisms of the food served in state hospitals justified? P. 518.
9. What are some fundamental reasons why poor food is served in state hospitals? P. 518.
10. Is it desirable to have graded charges in a community hospital? P. 521.
11. What is the responsibility of the social service department in follow-up work? P. 522.
12. How may the work of the social service department be distributed among the department's personnel? P. 520.
13. How can we get team work in establishing a case record department? P. 525.
14. Along what lines must a record department function to be efficient? P. 526.
15. What are the essentials of good newspaper publicity? P. 528.
16. How may a hospital cooperate with health agencies? P. 543.
17. What schedule of work should be arranged to give practical education to interns? P. 548.
18. What is the oldest hospital in America? P. 545.
19. How should we protect the nurse who is caring for a contagious case. P. 561.
20. What methods of sterilization are desirable after a contagious case is discharged? P. 561.
21. Is radio of therapeutic value? P. 557.
22. Do we eat enough fruit? P. 562.
23. What method of indexing best enables a dispensary to gather its statistics. P. 566.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
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SOME PROBATIONERS' IDEAS ON SAFEGUARDING THE MORALS OF STUDENT NURSES

BY MAJOR JULIA C. STIMSON, SUPERINTENDENT, ARMY NURSE CORPS, DEAN, ARMY SCHOOL OF NURSING, WASHINGTON, D. C.

AFTER a series of talks on nursing ethics given to the probationers of the schools of nursing in the District of Columbia in a central school conducted at the George Washington University Medical School, a topic was assigned for a paper to replace the final examination. The topic given was, "In what way can student nurses be safeguarded against moral dangers?" The group to which the topic was assigned was composed of 140 probationers, comprising the preliminary classes of eight schools of the district.

A brief study of the papers, and an informal classification of the young women included in the group is of interest.

To this end the superintendent of nurses of each school represented the group was asked to supply a few facts about the students from her school. The facts requested concerning the students were: age, residence, and education. From this data it appears that seventy-eight and one-half per cent of the entire number were between eighteen and twenty-one years of age; thirteen and one-half per cent between twenty-two and twenty-five years, and only about eight per cent between twenty-six and thirty-one years. The great majority of the students were obviously of college age.

Small Town Supplies Most Nurses

The classification of the residences of these 140 young women was made by roughly dividing them into two groups, urban and rural. By using a rough estimate of population for town and city districts from which they came, it was fairly easy to place their home towns in these two divisions. More than seventy-seven per cent, or three quarters of the entire group, came from the rural or small-town districts. Nearly twenty-three per cent belong in the urban group, or in what may be called large cities.

The educational requirements for the schools of nursing of the District of Columbia, with two exceptions, are but two years of high school attendance. The exceptions are one white and one colored school. The colored students are not included in this study. But of the entire group seventy-five per cent were high school graduates, or the equivalent, while twenty-five per cent had less (only part high school) education. The five per cent who had better than high school education would have been larger if the probationers from the one white school referred to before, who received credit for collegiate education, had been included in this course.

The suggestions made by this large group of students, none of whom had been four months in training, have been classified under several main heads. Of a total of 358 suggestions, sixteen per cent placed the responsibility of safeguarding against moral dangers upon the family, and eighty per cent felt the task should rest with the faculty of the school of nursing. The four per cent who felt that there was more need of sex education did not state where they thought it should be given. The suggestions that the safeguarding must be done in the homes through the development of character, self-respect, and all that is implied in home-training, need not be considered further at this time, except to hope that it will come to the attention of the parents.

Upon the faculties of schools of nursing or upon the alumnæ associations, (if we agree that the first object of such bodies is to promote the welfare of the school,) are placed serious responsibilities, if the ideas of these 140 young women are any indication. Great emphasis is placed upon closer contact between student nurses, their superintendents and supervisors. Twenty-five per cent of the young women spoke of this. Twenty-one and one-half per cent of them thought they should be able to be advised by their supervisors in their selection of places in the city where they could go for recreation and amusement.

Thirty-one per cent of them said they should have more talks on ethics (and this at the close of a series of five hour lectures—all that was considered necessary in the preliminary period for the group attending the central school).

Greater Personal Interest Necessary

That the officials of the school and older nurses should set better examples for the younger nurses was intimated by nine per cent of the students. Three and one-half per cent of them said that they thought the heads of the schools should have some knowledge of the students' friends, and their places of amusement. Nearly eight per cent suggested that more careful chaperonage was necessary. A number referred to the great difference between their home life and the life in the school of nursing, and wished to find a more motherly attitude in their instructors and directors in order to promote the discussing

of personal affairs with them.

With considerable unconscious pathos several referred to the feeling of inferiority as if they were but a cog in the wheel of a large machine, and stated that their thoughts and actions while off duty made no difference to anyone. They evidenced a longing for personal interest and the ability to go to older, wiser women for the interest and sympathy they were accustomed to have in their own homes. Curiously enough, not one of the girls who wrote seemed to realize, or at least to the extent of expressing it, the tremendous drain of energy and the amount of time it would take from superintendents, supervisors and directors, aside from their professional work, to be to these young women all they desired.

Whether this points to the need in every school of nursing of a house mother or social worker, whose sole business would be the welfare of these young women, or whether it indicates that the minimum age requirements for our schools of nursing should be raised until these girls are not in so great need of sympathetic support and advice, are questions which need study. Personally, I think the solution of the problem lies in another direction.

Twenty-seven and one-half per cent of the young women spoke with considerable vigor upon the need of more emphasis upon the spiritual life of nurses. Some thought daily chapel exercises were very helpful, and many of the number referred to the need of weekly church attendance.

Better Recreational Facilities Desired

With regard to more material things, one-third of the group urged more entertainment in the nurses' home. Better living conditions, pleasanter places for entertaining company, and the development of athletics and sports, with proper places for them, were also mentioned. One suggestion was that there should be a special person whose duty it was to direct in matters of this sort. Several referred to the need of a gymnasium in connection with the nurses' home.

In still another interesting way, the burden of responsibility was placed directly upon the shoulders of the school officials. The harmful influence of the presence of undesirable students in the school was referred to by six and one-half per cent of the probationers. Several said there should be more careful choice of young women admitted to the schools. One spoke of the unfortunate effect of unmoral doctors on the students, and one mentioned the malignant influence of certain nurses with whom she came in contact in the hospital.

With regard to rules, there was considerable difference of opinion, but the answers can be thus summarized: Eleven and one-half per cent felt that there should be fewer rules regarding small and unimportant matters, and most of these thought that the more rules there were, the more one was naturally inclined to disregard them. On the other hand, fourteen per cent of the group suggested a more rigid enforcement of the few fundamental regulations, with a careful explanation of the importance of each. Nearly thirteen per cent felt that with the honor system more carefully developed and with more evidence of confidence in the students on the part of the faculty of the schools as opposed to close supervision, there would be need for fewer regulations, and characters would be strengthened.

The matter of self-government was not referred to in a single instance. In the schools of nursing of the district there is not one example of well-developed student government. Two or three of the schools have class organizations, and one has a student council, but real self-government is entirely lacking. It would appear that the development of such an activity would help in the solution of our problems, for it stands to reason that participation in the establishment of a form of government, and responsibility regarding enforcement of its provisions, will result in greater interest on the part of the individuals concerned and a greater feeling of personal responsibility and obligation toward the group.

A few quotations from the papers of these probationers will point out their real need of friendly, personal contact with some human being not of their own group.

1. "The majority of young nurses who come into a large city from a small town at first become overwhelmed with the excitement of the environment and, in the search for pleasures, forget their purpose. In these instances, the older nurses and supervisors should instruct the student nurses and probationers, as to the company they should keep, places of interest for them to attend when off duty, and be sociable pals rather than too sedate critics."

2. "I believe that a clearer understanding, a more definite conception, a truer explanation of some of the dangers which beset a young student, would help her to realize more fully, that she needs to build a finer, firmer character, as a foundation upon which to base her judgment, a guide to her actions, a surer protection against dangers of which she heretofore has not been aware, and which in her guarded home life she probably never knew existed.

3. "We must consider the fact that most young students have never been away from their homes before, and are easily influenced by the actions of others. If the older nurses, and the faculty and teachers in the training schools would make the younger girls feel more strongly the real seriousness of their work and would themselves be above reproach in matters of actions, dress, and speech, the young girls would be likely to follow the examples set before them."

4. "I think that probationers can be helped in safeguarding themselves by personal interest. At home most of us have been used to the careful watchfulness and kindly advice and help of our parents, and they have always been ready to listen to our troubles. Here we are without that advice and help. The circumstances are so different that many of us who have not been out in the world long enough to make our own decisions do not know what to expect or how to handle the new situations. If we could feel a personal relationship, could go to some one who knew and could help us reach a decision, then we would feel we had the strength to do right. We often get confused in ideas, certain things strike us the wrong way, and often we spend days debating things in our minds and even then we are not sure we have arrived at a sane conclusion, whereas just a few words from our elders would help us so much. Of course there are many people who would be glad to help us, but how do we know? I would like so much to have someone older and more experienced to talk to in a personal way."

5. "I think if the student nurses were brought into closer relationship with their instructress so that they could discuss all sorts of things with her it would be of great help. I don't mean for the student nurse to be familiar with the instructress but rather to be able to feel that someone understands."

6. "A word of encouragement might save some girl from a rash deed done in a moment when she felt that no one cared."

The state of affairs is not unique. The same conditions must exist in all our schools, though of course in varying degrees. With this diagnosis what is the treatment?

MODERN METHODS OF TREATING COMMUNICABLE DISEASES SUCCESSFULLY

By MARGARET INGERSOLL, Johns Hopkins Hospital, Baltimore, Md.

METHODS of caring for patients with communicable diseases are constantly changing as our knowledge of the dissemination of disease increases. In the past ten years very radical changes have been made in the technique of isolation. For instance, fumigation is no longer thought to be necessary. Soap, water, and sunshine are the best disinfectants. At one time nurses caring for contagious diseases were not allowed to mingle with other people; now if good technique is used, they may go about at will. Precautions which are today considered essential may within a few years be looked upon as antiquated and new methods of isolation may be developed which are unthought of at the present time.

In order effectively to guard against the dissemination of contagion it is necessary to be familiar with the source, means of distribution, and portals of entry of the common, disease-producing microorganisms. A knowledge of these facts makes it possible to institute methods of isolation that will enable a nurse to take care of each type of case without danger to other people or to herself.

How Contagion Is Spread

Microorganisms which produce infectious diseases are found in the person ill with the disease or in the "carrier." The disease is communicated to others by direct contact, as when a nurse lays her hands on a patient; by droplet infection, as when one stands close to a patient who sneezes; by bedclothes or other contaminated articles; by food, milk, water and insects.

Pathogenic microorganisms may enter through the gastro-intestinal tract, through the respiratory tract, or by inoculation; Bacillus typhosus enters by ingestion, the Klebs-Loeffler bacillus by inhalation and the streptococcus responsible for erysipelas by inoculation.

Many contagious diseases must be treated in hospitals. This leads to the problem of the protection of patients who have no contagious disease, and of nurses who are caring for contagious cases.

In the children's department of the Johns Hopkins Hospital, Baltimore, Md., much attention is given to the treatment of communicable diseases. Patients suffering from any infectious disease, with the exception of measles, chickenpox or small-pox, may be admitted to the hospital. Patients often develop measles or chicken-pox after entering the hospital, having been exposed to the disease before admission. Under these conditions there is no time during the year when there is not a large number of infectious cases in the wards.

For complete isolation the patient is placed in a single room or cubicle. In this way many contagious diseases may be cared for in a small space with very little opportunity for cross infection. When there are epidemics an entire ward may be used for patients ill with the same disease and the attending nurse may go from one patient to another in the same isolation outfit.

The following technique has been found adequate for the protection of the patient not suffering from a contagious disease and for the nurses who are caring for the contagious cases. To protect her clothing the nurse must cover her uniform with an isolation gown when coming in close contact with the patient. This gown is put on upon entering the room or cubicle and is handled in such a way as not to contaminate her clothing. When the patient is suffering from a respiratory infection, a mouthpiece made of gauze is worn. In addition to the gown and mouthpiece a cap to protect the hair is worn in the care of scarlet fever, measles, varicella and diphtheria.

Dysentery and gonorrhea are two of the most dreaded diseases of infants. In caring for these patients extra precautions are taken. Before giving immediate attention to them the nurse removes her cuffs and rolls up her sleeves, then puts on a gown and rubber gloves. When the eyes of a patient suffering from gonorrheal ophthalmia are irrigated, goggles are worn to protect the eyes. When the nurse is ready to leave the room she scrubs her hands, takes off the mouthpiece, cap and gown, and scrubs her hands a second time before leaving the room. The gown is hung with the inner surfaces together when not in use. The mouthpiece is used only once and dropped in a paper bag kept in each room for that purpose. The gowns are washed daily and the mouthpieces boiled after being used once. Gloves are kept in a basin of antiseptic solution.

The soiled linen is dropped directly into a bag standing in a rack in the room. The bag is put in an uncontaminated bag before being sent to the laundry.

Nipples and dishes are taken to the kitchen and immediately put into the sterilizer. The food refuse is put in paper bags and sent away with other garbage. All gauze is put into paper bags and burned immediately.

Expose Bedding to Air and Sun

When a patient is discharged the mattress, pillows and blankets are sterilized by exposure to the air and sun for twenty-four hours, or are placed in a steam sterilizer. Articles made of rubber are allowed to remain in sanitary fluid (lysol) for twenty minutes. All utensils are boiled. The room and the furniture are aired and thoroughly scrubbed with soap and water.

In conclusion it may be said that for the successful and safe isolation of patients suffering from contagious diseases it is the observance of details which is essential.

It is highly desirable that the nurse caring for contagious cases should know the individual disease and its effect upon the patient. In dysentery it is vital to keep up the body fluids. This is accomplished by giving water hourly. Frequently it is necessary to give larger amounts of fluid than the patient is able to take by mouth. An intraperitoneal infusion of normal salt solution or an intravenous injection of five per cent glucose may be indicated. These treatments are given by the attending physician. Tap water or five per cent glucose is successfully given by nasal drip with very little discomfort to the patient. In pertussis, paroxysms of coughing often interfere with the baby's feeding and lead to vomiting. To avoid starvation from continued vomiting, he is refed the amount lost in this way.

In poliomyelitis the feet must be watched lest "toe drop" develops. A sand pillow at the feet meets this need, and a cradle serves to remove the pressure of the bedding.

Our knowledge concerning the use of convalescent's serum is increasing. Serums from recent cases of measles, varicella and poliomyelitis have been used with encouraging results in the control of epidemics.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
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THE USE OF FRUIT IN THE DIET*

BY LULU G. GRAVES, NEW YORK, N. Y.

THE value of fruit in the diet has not been long recognized and is not yet always estimated at its true worth, probably because of its comparatively low nutritive value. Citrus fruits have been given a prominent place in hospital dietaries for some time; other fruits are gradually assuming their rightful place, and are no longer considered a luxury.

Fortunately, fruit of some kind is now to be had in the market during all seasons, in all sections of the country. If fresh fruit is not obtainable there are available good grades of canned or dried fruits, in addition to jams, jellies and marmalades. Methods of storing and transporting fruits have been so perfected that almost all fruits are available in the fresh state in city markets during the entire year; apples, bananas, citrus fruits and usually a few others are always available in rural markets. It is not necessary and not always desirable to use fruit out of season, even if one disregards the price; frequently the flavor of these fruits is not well developed and they are not so palatable as the fruits which are in season; the carbohydrate may not have been as completely changed as it should be in a well ripened product, hence not as easily digested.

Value as an Aid in Digestion

The value of fruit in the diet is by no means confined to the nutrients present; the part it plays as an aid to digestion is important, and its esthetic value is not to be ignored.

The chief nutrients are of the carbohydrate group. Though a small proportion of protein and fat are found in some fruits, they are, with few exceptions, not in sufficient quantities to be given consideration in the average normal diet. One notable exception is the avocado which may have ten to twenty per cent of fat. The carbohydrate is principally in the form of sugar with lesser amounts of cellulose and pectin bodies. This varies in different fruits in accordance with the degree of ripeness, the lowest percentage of sugar being found in fresh fruits and the highest in preserved and dried fruits. The sugars are sucrose, or cane sugar; glucose, or grape sugar; and levulose, or fruit sugar; the last two usually being present together and in equal quantities are called invert sugars. Exceptions to this arrangement of invert sugars are found in some varieties of grapes and such dried fruits as prunes, figs, raisins, which have more grape sugar than fruit sugar, and in sweet apples, sweet pears and some sour grapes, in which fruit sugar predominates. It is said that the mango has fruit sugar but no grape sugar.

Cellulose Furnishes Bulk in Diet

Cellulose in the fiber, skins and seeds of fruit also varies in different fruits and decreases somewhat as the fruit ripens, the amount of cellulose is also decreased by cultivation. Cellulose has practically no nutritive value, but it furnishes bulk in the diet. Pectin bodies likewise have practically no food value and these diminish to an even greater extent during the ripening process, as every housewife learns in her experience with jelly making.

The percentage of organic acids in fruit is low. Figures would seem to indicate that they are of no consequence, but such is not the case. In the body these acids are changed to carbonates which function as a potential base, thereby helping to neutralize the acids produced by the metabolism of meat and other acid forming foods. Diets planned with the proper proportion of alkali and acid forming elements help to maintain the neutrality of the blood. Acidity of the blood and urine may be reduced by the same means. Some of the foods which help to reduce the acid of the urine and are thus helpful in nephritis are apples, bananas, canteloupes, and raisins. Fruits containing benzoic acid, thereby making the urine more acid, are cranberries, prunes and plums. Citrus fruits have a considerable degree of acidity. However, fruits having the same acid content may not taste equally sour because one may have more sugar than the other.

Content Eighty to Ninety Per Cent Water

Approximately eighty to ninety per cent of fruit is water. For this reason it is classed as a food having low nutritive value. This is not a total loss from the standpoint of food value, since we are known as a people who drink too little water. For large numbers of people the fruit consumed helps make up this deficit. Since water is necessary to the body and as it is constantly being eliminated by the skin, lungs, and kidneys, it must be replaced.

As an aid to digestion fruit provides organic acids, which may help in the secretion of the digestive juices, essential food factors or vitamins; laxative sugars; bulk which stimulates peristalsis and water which aids in carrying the food material produced by digestion to the cell, and in the removal of waste products.

The esthetic value of fruit is in its attractive appear-

*This is the first of a series of articles on fruit in the diet, prepared for THE MODERN HOSPITAL by Miss Graves.

ance and its pleasing aroma and flavor. The latter are due partially to minute quantities of ethereal bodies having no nutritive value but giving to the several fruits a distinctive flavor and odor which are stimulating to the appetite and an aid to digestion.

Fruits Combine Well with Other Foods

Nearly all fruits combine well with some other food materials, with cereals for breakfast; with cream, custards, frozen mixtures or as a combination of fruits for a dessert; with nuts, celery, lettuce or other salad ingredients for either luncheon or dinner, not to mention sandwiches or sweets and the numerous jellies, jams and marmalades. This makes it possible to have fruit in some form as an established part of the dietary.

Because fresh fruit is appetizing and refreshing, it is sometimes eaten injudiciously when under ripe or over ripe, or eaten in too large quantities. Unripe fruit often causes intestinal irritation, probably due to the large percentage of cellulose which is not well masticated or to the excess of acid. These difficulties may be overcome by cooking green fruit. Over ripe fruit has a tendency to ferment in the intestine, and may often be injurious because it is partially decayed.

Fruits should be thoroughly washed before using, even if bought in packages. Unfortunately this precaution is often neglected in hospitals, both in the kitchen and on the wards. Whether fruit is packed under the trees in an orchard or in a clean sanitary packing house, it cannot possibly be free from dust and other possible contamination from being handled by many people or standing in railroad yards or on wharves. Then, too, after it has reached the retail market, fruit in boxes or crates is exposed to the usual handling, by all manner of hands, and many garments of many kinds brush over it. Dried fruits require very thorough washing, especially those with sugar coating or those which are soft and sticky, such as raisins, dates and figs.

The Proper Treatment of Berries

Early summer fruits such as berries, which mash easily, may be washed by putting them in a collander or coarse sieve and dipping them in a pan full of water, or holding them under a faucet and letting water flow over them with little force. This washing process should be finished quickly and the berries not allowed to stand in water. They should be washed before hulling or stemming them, so as to retain as much juice as possible. The juice is the most valuable part of berries; it is a solution of sugars, pectin, mineral salts, acids and flavoring ethers. The cultivated berry is generally an improvement over the wild berry, though sometimes in cultivation, flavor is sacrificed to size. Well ripened juicy berries are sufficient unto themselves as a wholesome refreshing dish to serve. Their food value is increased by the addition of sugar or cream, but such addition is usually unnecessary and is often destructive to the natural fruit flavor. If, however, the supply of berries is limited, or if time for preparation is at a premium, they may be combined with other food materials, in a palatable way; crushed and mixed with beaten egg white to make a snow, or baked in a soufflé, or with whipped cream in a mousse or parfait. With gelatin numerous dishes may be prepared. When combined with less perishable fruits, apples, pineapples, bananas, more nutritive value is derived and labor is lessened.

Because the season for berries is so short and the crop is apt to be abundant, many ways of preserving them have been devised. Jams, jellies, marmalades are too familiar to need discussion, but a choice secret in preserving is the combination of flavors. Some of the fruits that blend well in marmalades and preserves are red currants and red raspberries; white currants and gooseberries; black currants and apples; rhubarb and currants; rhubarb, oranges and nuts; pineapple and strawberries; gooseberries, raisins and either oranges or nuts; black raspberries and rhubarb; cantelope preserves flavored with rose extract or petals.

Blackberry juice with sugar and spices has dietetic value aside from being a delicious beverage. It is used in cases of dysentery and so-called summer complaints. The blueberry or huckleberry is of a family variously and contradictorily named in the market. These berries are hardy enough to stand transportation and storing better than the above mentioned berries, but they are used chiefly as sauce or for pies. These have not been cultivated to the extent that the others have, as the wild fruit meets the demand, but they are quite worthy of more attention, both in the cultivation and on the menu.

Loganberry Well Adapted for Sick Use

The loganberry is the result of crossing the red raspberry and blackberry. It is grown more extensively in Oregon and Washington than elsewhere and is used chiefly for canning and for its juice. Loganberry juice is well adapted to the diet of the sick. It is refreshing and because it is not so sweet is less apt to be nauseating or distasteful to patients with high temperature.

Gooseberries are of the same general family as currants. Their tartness makes them especially good for combining with other and sweeter fruits. Therefore, they are used more in jams and preserves than as a plain fruit. Currants are usually associated in the hospital with the dried fruit, and will be discussed further in connection with dried fruits. However, the above mentioned combinations of currants and other fruits are not difficult to prepare nor very expensive. Clusters of ripe currants are effective as a garnish for desserts and salads.

Raspberries and strawberries are popular with patients as well as with people who are not ill. In season, when they are not so expensive they may and should be used freely. Often chilled fresh berries on a tray will tempt a patient to eat his food when he will not otherwise do so.

Pies and shortcake are out of place in a discussion of hospital service, but what nurse or doctor would consider them out of place on a menu?

Other fruits on the market in the early summer are cherries and canteloupes. When cooked, the sour red cherries afford a pleasing variety either for dessert or for a breakfast fruit, as other fruits in season at that time are generally of the sweet variety. The juice of these cooked cherries may be used in many ways to flavor jellies, custards or ices and other frozen desserts. Drinks made of fruit juice may well be substituted in some instances for the invariable orange or lemon drinks. Cherry juice is especially delicious when used in this way. The maraschino cherry is an ever present help in the hospital menu solely because of the attractiveness it adds to the service. It is prepared by bleaching the fruit in a solution of salt and sulphuric acid. This is usually done in France. After reaching this country it is washed, saturated with sugar or glucose solution, colored and flavored with oil of bitter almonds or occasionally other flavors. The cherries are then bottled and sterilized. Maraschino juice may be used for flavoring desserts or fruit drinks.

The ever popular melon, as other early fruits, has a high percentage of water and little nutritive value. Cante-

loupes have about ninety per cent of water and eight per cent carbohydrate and watermelons as high as ninety-two per cent of water and only six to seven per cent carbohydrate. Casabas, canteloupes and similar forms of melons are deservedly popular. They are appetizing and refreshing and, as before stated, their water content is an advantage in the diet in summer, as we do not need a menu so high in caloric value as is required in colder weather. Therefore, these fruits give us an acceptable variation during the short time they are in season.

HOW SPECIAL DIET RESTAURANTS SPREAD THE FOOD GOSPEL

By MARY A. FOLEY, Kahler Corporation, Rochester, Minn.

CALORIE kitchens and dietetic restaurants are the latest acquisition to the dietetic field, and they are a joy to those who must patronize hotels, restaurants and cafeterias.

The widespread demand for diet restaurants in various parts of the country, and the innumerable requests for information regarding the formation of such restaurants, show the need for available data on this subject. The story of the calorie kitchen in Rochester, Minn., may be of value to those interested in such a service.

The Rochester Calorie Kitchen was opened November 1, 1922, having for its aim the theoretical and practical instruction of patients on special diets, or, in other words, the dissemination of the food gospel. The kitchen and dining room of one of the small hotels were turned over to us, and we proceeded—with many doubts and much hesitancy.

The situation in Rochester is somewhat unusual as the clientele of the clinic is drawn not from one city or one state, but from all over the United States. The time entailed in coming to the clinic, undergoing the examinations and tests necessary for accurate diagnosis, and making the journey home naturally makes the patients anxious to spend as short a time as possible in Rochester. This factor was instrumental in retarding our growth. From the beginning we had insisted that each patient referred for dietetic instructions must stay at least four days, for which a charge of ten dollars is made.

The patients are referred by physicians, and no patient, regardless of who he is or the type of diet he desires, is allowed to eat at the calorie kitchen without a prescription from a physician. General referring cards are used by the clinic physicians, each card bearing the name of the patient and of the physician, the registration number and date, the type of diet necessary and the reasons for requesting the diet. Physicians not connected with the clinic write us a personal note, giving us similar information although not in so concise a form.

GENERAL REFERRING CARD.

Name..... No. A.....
Date .....C. H. W. P.
Referred to Dr.....
Referred by Dr.....
Referred for .....
Reason for Requesting Test.....
Report .....
.....
.....

Each patient is interviewed by a dietitian before beginning his dietetic regime. We feel that this is most important as it gives us an opportunity to pick up many interesting facts relative to their previous diet and food habits, and at the same time to establish the personal contact which is so essential for constructive work.

In a recent article, Michael Davis, Jr., executive secretary, Committee on Dispensary Development, New York, refers to "the dietitian who sees only her end of it and does not think about the other conditions, is too interested in her own special field and pays too little atention to the contributing causes of the complaint." A broad, sympathetic view of the specific and contributing conditions plays an important part in the plan outlined for the patient.

Lectures Stimulate Interest

The ten dollar deposit made at the first meal covers not only the twelve consecutive meals but also personal instructions, printed matter, recipes and all subsequent correspondence. Lectures are given several times a week to stimulate interest, arouse enthusiasm and furnish a foundation on which to build the instructions for the particular, individualized special diet.

At the end of the four days, after the instructions are given, a short history is written on the back of the general referring card, which is filed at this time, only to be taken out at the end of a month when a follow-up letter is written. The replies to these follow-up letters are illuminating. Some of the letters sound like testimonials and others, perhaps the ones from which we derive the most benefit, give us constructive criticism.

The value of such a restaurant in Rochester has been very clearly demonstrated, and with the help of the generous cooperation and interest of the physicians, and the enthusiasm of our former patients, the number of patients has grown, until in February our average was ninety per meal.

Is the Rochester Calorie Kitchen a financial success? It has not been so in the past, but we feel sure that the year 1925 will show a decided profit. Last year February showed a deficit of $200, in comparison with a profit of $284.55 for the same month this year. This profit, we are sure, will bring us out on the right side of the ledger for the year 1925.

Dietitians, as a class, cannot afford to undertake a venture from purely altruistic motives and therefore some may hesitate to risk their capital. After two years' experience in this type of work I am firmly convinced that dietetic restaurants may be a financial success, provided you have volume and the cooperation of the physicians, which is of vital importance.

Close analysis of our financial report for February, 1925, brings out several points of interest. First, the amount allowed for dietitians' salaries is rather high. Hospitals and clinics are teaching institutions, and dietitians must be available for teaching student nurses in the diet kitchen, and for the instruction of doctors and other visitors who are interested in preventive medicine. Second, we have a standard price regardless of the type of diet ordered. A patient on a 1,000 calorie diet pays ten dollars, as does the individual on a 5,000 calorie diet. A patient requiring one instruction period of half an hour pays ten dollars, as does one requiring six instruction periods. This plan, for various reasons, has seemed

feasible to us in Rochester, but could be changed very easily, and definite rates established for the various diets and a charge made for instructions.

ROCHESTER CALORIE KITCHEN

Patient's Name .....

Diet .....

MEAL HOURS

Breakfast—7:45 to 8:45 a. m., 50c
Dinner—12:00 to 1:00 p. m., 70c
Supper—5:30 to 6:15 p. m., 70c

NOTICE—After arrangements have been made with dietitian your meals are prepared in advance, and unless we are notified one hour previous to serving time that you will not be here, we will expect payment for meals whether served to you or not.

PHONE 2717

Success or failure must not be measured solely by a financial report. It is hard to estimate the full value of the calorie kitchen. The satisfaction of the patient is evident, the results are satisfactory, but the broader educational significance of such an organization cannot be measured. There is no question that much good for the community is being accomplished, as each patient carries to his home circle valuable and definite information concerning foods and nutrition, in this manner spreading the food gospel.

The following table shows the number of trays served in February, 1925:

Anti-constipation	3,188
Bland anti-constipation	205
Reduction	952
High calorie	336
Ulcer	208
Post operative ulcer	220
Hyperacidity	92
Achylia	71
Blind	9
Post operative gall-bladder	12
Nephritic	19
Diabetic	13
Ketogenic	302
Low carbohydrate	86
High protein	5
Acid free	115
Basic	35
Total	5,868

DIABETIC FOODS AND THE MARKET

There are to be found in our present markets many so-called diabetic breads and flours, foods claiming to do for the obese that which they fail to do and other food materials purporting to have more or less merit in specified diseases. The dietitian and nutritional worker must be constantly on the alert, in order to be aware of the beneficial ones and beware of the others. This is particularly true, because of the constant and somewhat rapid changes in the treatment of metabolic diseases, which necessitate a great deal of experimentation in dietotherapy. We are therefore appreciative of new materials that are helpful.

Protein cereal is a comparatively new product made from gulten of wheat. Having been treated by a special process, it is as pure protein as can be obtained. It has very little carbohydrate and is practically tasteless, which makes it well adapted for use with other food materials.

Preliminary studies would seem to indicate that it is beneficial in the diets for obesity, tuberculosis and diabetes and possibly in nephritis. In the treatment of obesity, it has been found that a high protein diet may be used with satisfactory results and with safety, because protein is practically all utilized in the body, a small percentage only being deposited as fat in the body, except when fat and carbohydrate are used in sufficient amounts to meet all requirements; and since protein stimulates metabolism, the body tissues may be more readily consumed with a high protein diet and the rate of reduction increased. Protein cereal supplements lean meats with a form of protein having no extractives and it furnishes bulk.

In cases of tuberculosis and diabetes, it is a good medium for getting fat into the diet, as large quantities of cream may be served with it. In tuberculosis, especially, further nutritive value may be given by the addition of fruits of various kinds; prunes, raisins, dates, baked apples and bananas are valuable additions to the cereal, as are fresh berries, in season.

Even in diabetes, smaller portions of fruit may be served in this way if the carbohydrate prescription is high enough to permit it. To be sure, this is equally true of other cereals, but they are used under different conditions, as they are high in carbohydrate and low in protein, while the protein cereal is just the reverse.

In cases of diabetes indicating a prescription low in animal protein because the extractives are objectionable, the vegetable protein is a desirable substitute. Grain products are less acid forming than meat. This is also a less expensive form of protein and it helps furnish bulk in the diet. Because this is a new product, not a great deal of data as to definite results obtained are available, but experimentation is being continued in several departments of metabolic clinics and it promises to be a product of worth in dietotherapy.

PROTECTING CAVIAR BY LABELS

Caviar is a product generally prepared from the eggs of the fish known as sturgeon. When the product is made from the eggs of other fish than sturgeon food control officials hold that the label on the product should show the name of the fish from which derived. State officials and Federal officials are finding products on the market labeled as caviar which instead of being a sturgeon roe product, are products actually made from white fish roe or other fish roe. Action is being taken against the sellers of such misbranded articles. The *American Food Journal* understands that because of the physical dissimilarity of the eggs usually substituted in part for sturgeon eggs, it is an easy matter to discover whether or not products labeled as caviar are adulterated, even though substitute roe mixture may be artificially colored.—Notes from Food Officials *American Food Journal*, April, 1925.

MINIMIZING CHINA AND GLASS BREAKAGE

The steward of the Kahler Corporation, Rochester, Minn., found that the greatest amount of dish breakage occurred through careless handling, particularly when the buss boys were unloading their trays. The majority dumped the dishes in a manner resembling a wagon unloading coal.

When he discovered this situation he personally instructed all the boys in the proper and careful handling of both the dishes and glassware. He next watched the dishwashers, and made several constructive suggestions. He made it a fixed rule, for example, that all silver and glassware be separated from the china before leaving the dining room. This not only facilitates the work of unloading, but prevents the jarring and chipping of the chinaware. When the glassware reaches the kitchen, it is not placed in contact with hot water or steam until the chill has worn off, as many glasses were cracked by being placed in hot water before the chill had worn off. Another rule he made is that no glassware is to be stacked, as the weight of the top layers chips the lower glasses—*Hotel Management*, March, 1925.

(For dietetic news notes see p. 569.)

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York 15 W. 43rd Street, New York

YARDSTICKS FOR OUT-PATIENT DEPARTMENT SERVICE

BY FLORENCE G. BABCOCK, FORMERLY RECORD LIBRARIAN, BOSTON DISPENSARY, BOSTON, MASS.

THE Boston Dispensary, just as most other dispensaries, collects routine statistics on clinic enrollment and attendance. Unlike many other dispensaries, however, its machinery for collecting these figures is simple, inexpensive, and unusually fruitful.

The collection of statistics is often regarded as a burden but this is largely due to the cumbersome methods which are employed. Hence, it may be of interest to describe the method used at the Boston Dispensary which has proved so convenient both to those collecting these statistics and those who make use of them for the information of the staff and directors of the institution and of the public.

Card Index Method Used

The method employed is essentially the card index method and works about as follows:

When the patient comes to the cashier, after registering at the admission desk, a stub is made out, bearing his case number, the clinic he is to attend, and the date. This stub is sent to the record room and used when pulling his history from the files. At the close of the day, the stubs are collected and entries made from them in the statistical index.

A separate index card is made out for each patient each year. If, for example, the cashier's stub shows that on January 5, patient number 236,500 has attended the medical clinic, the clerk looks in the index, under 236,500 to see if a card has yet been made out for that patient. Finding none, she makes out a new three by five card, similar to that shown here. The patient's number is in the upper right hand corner, the year in the center, the name of the clinics across the top, and the dates when the patient visits those clinics are entered in columns below.

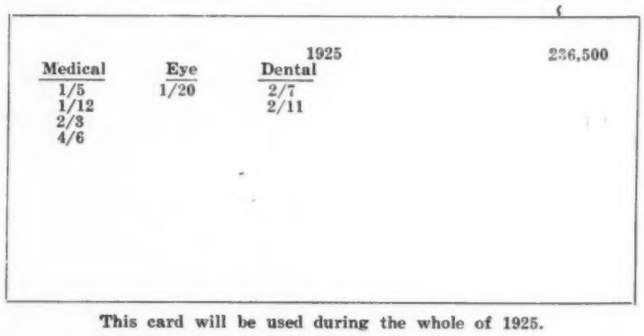
When all the visits for the day have been entered on these cards, a daily tally is made, which shows how many of the patients who came in on that day were new to the dispensary, or old patients returning for the first time during the current year; and for each clinic department, how many were making the first visit in the year, or the first visit in the month.

By this method we can tell at the end of each month just how many individuals have reported to each clinic, and from month to month just how many individuals have reported to the Boston Dispensary for the first time during the year.

Card Index Method

THE card index method used at the Boston Dispensary for gathering statistics of clinic enrollment and attendance assigns one card to each dispensary patient each year. The card shows how many different clinics the patient has attended, and how many visits he has made to each clinic. Daily, monthly, and yearly reports are compiled routinely from these cards. In addition, many special studies can be made at short notice by quick cor[illegible]ing of the cards.

The installation of the card index system immediately resulted in decreasing the amount of clerical work necessary to compile the routine figures which every dispensary must gather. The cost is actually less than it was before, the figures are secured much more promptly, the information given is of considerably greater value, and the system is adaptable to many special studies of administrative or scientific value.



1925 236,500

Medical	Eye	Dental
1/5	1/20	2/7
1/12		2/11
2/3		
4/6		

This card will be used during the whole of 1925.

The time required to keep up this index is between two and three hours a day for an average of 500 visits with a maximum of about 800. This means that the work can be done in between fourteen and fifteen seconds per visit, a marked reduction from the clerical time required by the statistical methods which were previously used. Three of the record room clerks divide the stubs among

New Patients				Old Patients Admitted to New Department								Total Patients to a New Dept.	Old Patients Returning to Former Dept.				Total Visits
				By Admission Desk				By Transfer from Physician					First Time This Year			Previously here this Year	
Men	Women	Children	Total	Men	Women	Children	Total	Men	Women	Children	Total		Men	Women	Children	Total	

them, and spend an hour each morning after admission hour is over in making the entries. The monthly and yearly reports are simply compiled by transferring the totals of daily tallies.

Methods Formerly Used

Before the central record room at the Boston Dispensary came into being, statistics were meagre. In those days a daily enrollment and attendance sheet was kept which showed the following items for each clinic department:

This daily count told us how many different patients had attended each clinic department so far during the year, but it did not tell the number of patients who had attended the dispensary. To get this figure an elaborate and nerve racking count was made four times a year.

At that time, the records in the record room were kept, not in cabinets or on shelves, but in open boxes on long tables. The entire unit of boxes was divided into sections, according to three-month periods. As the patients reported for treatment the records were summoned to the clinics by means of number slips and as these slips came from the cashier to the record room, the clerk would look for the record first in the active file; if not found there, would go to the second section which contained records bearing a date of three months previous to those in the active file; if not found there, would go to the third section which contained records three months older than those in section 2; and if not found there, would finally go to the unassembled file where old records were filed by clinics.

At the end of each three months the clerks would count all the records for the previous three-month period and interfile them in an inactive file. These were filed in cabinets which had already been added to the filing equipment. This process of counting and interfiling was commenced about three in the afternoon and lasted until late in the evening, oftentimes the clerks not leaving the record room until nearly midnight. When once started the process had to be finished the same day, as the count would all be changed as soon as patients arrived the next day. After this report was finished the clerks could tell with a fair amount of accuracy how many individuals had reported to the dispensary during the past three months.

The next step forward was a statistical sheet devised by the social service department and kept in each clinic. This sheet is shown below.

It will be noticed that in this table a column was devoted to patients reporting for the first time to a particular clinic, thereby giving the number of individuals to that clinic, but when the statistics from all the clinics were summed up we were no nearer the solution, because of the fact that each patient usually visited more than one clinic and was thus counted again and again.

Serious disadvantages were also found in using the statistical sheet checked in each clinic. The method was intricate and also required that the nurse, social worker or executive of each clinic serve as an attendant statistical clerk for her clinic.

Things drifted along in this fashion until some time in 1922 when a meeting was called to discuss clinic problems, and the question of how to get the correct number of individuals coming to the dispensary once more arose. The superintendent thought it was the business of the record department to solve that problem. The challenge was accepted and as a result the present statistical index was introduced and is still in use, as it is, day by day growing more valuable.

Special Studies

The card index method for gathering clinic statistics may easily be adapted for the gathering of many sorts of information. Studies may be made readily, within a few hours, which, under most other systems, would require weeks of special research. For example, recently an argument arose concerning how much the different clinics were using each other. Specifically the dental clinic claimed that its patients from the medical clinic were too few; while the medical clinic countered by saying that it actually was being generous in its use of the dental clinic. A quick count of cards showed how many patients had attended the medical clinic, and of them how many later

(Continued on page 569)

Statistical Report	NEW						OLD									
For Month of Jan.	Never before admitted to disp.	Previously admitted to disp. but 1st time to this clinic.			Total New	1st time in cal. year.	Carried Forward. previously in cal. year.	Reinstated.						Total Old	Total Ind. for month	Total for yearly count	Visits
								1st time in cal. year			Previously in cal. year						
		Readmitted new from another Dept.	Refer New	Transfer New				Voluntary	Refer	Transfer	Voluntary	Refer	Transfer				
Previously in Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

FIRE PREVENTION DEPARTMENT

Conducted by W. M. Krieger, Engineer,
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PROTECTING THE HOSPITAL AGAINST WINDSTORMS

THE luxury of yesterday is the necessity of today; that which was a novelty twenty or thirty years ago is now a commonplace. How did we ever get along without street cars, telephones, automobiles, radios, modern plumbing and other conveniences?

The same question might be asked—how did we ever get along without windstorm insurance? Most sound business men today recognize that windstorm insurance is just as necessary as fire insurance. Why? Because every year there is a toll of hundreds of thousands of dollars loss of property in the Middle West as the result of destructive windstorms. It may be that these storms do not assume the character of what is commonly called a tornado with its twisting funnel of inky blackness, but the destruction is oftentimes greater on account of the much larger territory covered.

A children's hospital which was recently destroyed in a heavy windstorm. A baby was blown out the marked window on the second floor.

Judging by records compiled with painstaking care by the United States Weather Bureau, tornadoes last year were no respectors of states, especially those east of the Rockies. At least 110 are known to have occurred and they struck in twenty-three states scattered all the way from the Atlantic seaboard to Colorado and Montana. They were most numerous in the Middle West and South, but the damage in the East also ran into large figures. One that occurred within fifty miles of Boston, Mass., July 17, caused property damage estimated at $1,000,000, and a violent windstorm less than fifty miles from Washington, D. C., destroyed property to the extent of more than half a million dollars.

The total property damage for the country was over $24,000,000 and, according to official records, approximately 355 human lives were lost. More than 75 per cent of the loss, both in lives and property, was east of the Mississippi river. Seven states reported damage in excess of a million dollars each.

This total property damage of twenty-four million dollars represents the value of 4,800 homes, costing $5,000 each—enough to make a city street 192 blocks long with twenty-five houses to the block.

In a number of these violent storms Kansas led the list with seventeen, but Georgia and Alabama were not far behind. The greatest destruction of life and property was in eastern states where population is more dense. This emphasizes the statement that, as the country becomes more thickly settled, damage from these violent windstorms will almost inevitably increase. There is no scientific basis for thinking that tornadoes are increasing in number or occurring in the East more than formerly, but when the path of such a storm happens to strike a city the destruction left in its wake is apt to run into millions of dollars.

The outstanding tornado disaster of 1924 was at Lorain, Ohio, where seventy-three persons were killed, 200 injured and a loss of $11,000,000 in property damages. Destruction to adjacent territory increased the total loss of life to eighty-three and the total loss of property to $13,000,000. There is no particular reason to think this storm was more violent than many that did small damage, but it happened to strike near the center of a city of 37,000 while most of the others were in more open country.

According to Weather Bureau records, twenty-one distinct tornadoes occurred in the space of two days, April 29-30 last year with a property loss of $4,000,000 and killed 114 persons. One of these occurred in Arkansas, two in Louisiana, five in Alabama, eight in Georgia, one in South Carolina, two in North Carolina and two in Virginia.

The exact cause of tornadoes is a topic of much discussion. The order of events is usually the same; a warm day, thunder showers, in the afternoon or evening, violent hail, the tornado followed by rain.

The two most logical explanations are: During the passage of a storm area it often happens that the wind, blowing violently from one direction, will change in short order and blow just as violently from the other. At the "wind shift line" there are enormous eddies and whirls of air. Occasionally these become sufficiently powerful to form the funnel cloud.

Again, during the squalls of spring, the sun continues to heat the earth's surface during the moments of fair

weather. This sets up a strong local convection (rising of air) from the surface, which unites with that causing the squalls above, and the two form the whirling funnel.

Tornadoes are no respectors of persons or localities. No city, town, village or farming community in any state is immune from the ravages of this terrible visitor. Thus, the question arises in our minds, why it is when the storm is over and an accounting is taken that we find very often that little or no tornado insurance has been carried by a majority of the sufferers, while fire insurance policies on the property destroyed are held in most cases.

The premium asked for tornado and windstorm protection is low enough so that any hospital can afford the expense, for if the property is worth owning at all, it is worth protecting.

As fire insurance affords protection against one of nature's most destructive agencies, so windstorm insurance supplies a similar economic safeguard against financial loss resulting from havoc that may be wrought by wind. Fire and wind, both beneficent resources for man's well-being and prosperity, when safely harnessed to do his will, become ruthlessly destructive monsters when not harnessed. Fire loss may be, and often is, trivial, only rarely reaching the magnitude of a conflagration, but windstorm losses are practically always devastation which sweeps all property into heaps of ruins over large expanses of country. Also, loss by fire may be prevented or reduced by proper construction and intelligent care, but against windstorm losses man is helpless. If it is wise and logical to protect your hospital against loss by fire through insurance, is it not even more the part of wisdom to anticipate loss by windstorm—which includes tornado, cyclone and hurricane and is therefore adaptable to all sections of the country? Combined fire and tornado insurance is complete coverage.

YARD STICKS FOR OUT-PATIENT DEPARTMENT

(*Continued from page 567*)

went to the dental. Of course, it could not be proved that all of these dental patients had been referred by the medical, instead of going on their own initiative, but the figures were so low that the contention of the dental clinic had evidently some foundation. Once the figures were made known, the medical clinic increased its refers, the dental decreased its criticisms, and everyone was satisfied.

It is easy to compute from the cards the number of patients who, in a given period, reported but once to a clinic or, on the contrary, the number of patients who had the dispensary habit and made many unnecessary visits which slipped the doctor's attention.

At the end of a year the file may be used in its entirety for special studies, without disturbing the new active file. If desired, a summary of the preceding year may be brought forward on the back of the current year card. This would tell the story of each individual's career from the time he was admitted to the dispensary. One other fact worth mentioning is that in case a record cannot be located, either because of misfiling or some other carelessness, the cards show just the course of travel the patient has taken. In the case of a record missing for a given date it is fairly easy to look over all cards and select like dates and clinics, and go through these folders for the missing record. Though these cases are not frequent, when needed, this extra check is invaluable.

While a more complete method may be easily worked out, if one wishes to follow certain studies, and has the time to enter the information daily from the records, the scheme now in use seems sufficient for the present needs of the Boston Dispensary. This index file has so automatically worked into the scheme of things that it now seems impossible to think of record room efficiency without it.

In poliomyelitis the patient's feet must be watched lest "toe drop" develops. A sand pillow at the feet meets this need, and a cradle serves to remove the pressure of the bedding.

Our knowledge concerning the use of convalescent's serum is increasing. Serums from recent cases of measles, varicella and poliomyelitis have been used with encouraging results in the control of epidemics.

DIETETIC NEWS ITEMS

Miss Harriet Wells who has been dietitian at Brooklyn Hospital for five years, has accepted a position at Seaside Hospital, Staten Island, N. Y. Miss Marion Chesterman, who was Miss Wells' assistant for about two years at Brooklyn Hospital, has been appointed chief dietitian. Miss Jane Herenden, who was also one of Miss Wells' assistants, is Miss Chesterman's first assistant at Brooklyn Hospital.

Miss Ellen Gladwin was married in Philadelphia, Pa., on March 28 to Mr. Walter Ganister. For a number of years, Miss Gladwin has been dietitian at Jefferson Hospital, Philadelphia. Mr. Ganister has also been connected with this hospital. They are at home at 8 Prevost Avenue, Wyncote, Pa.

Mrs. Agnes O'Dea is administrative dietitian at Presbyterian Hospital, New York City.

Miss Alice Jackson, Toronto, Canada, is assistant dietitian in the administrative department of Presbyterian Hospital, New York, N. Y., under Mrs. Agnes O'Dea.

Miss Elizabeth McArthur, Appin, Ontario, has accepted a position of assistant dietitian at Seaview Hospital, Staten Island, N. Y. Miss McArthur was previously at Metropolitan Hospital, New York, N. Y.

Miss Phyllis Seige, who has recently been at Seaview Hospital, Staten Island, N. Y., is at Flower Hospital, New York, N. Y., as assistant to Miss Estelle Barker.

Miss Lillian Stowell has finished student training at Fifth Avenue Hospital, New York, N. Y., and has been appointed dietitian at St. Peter's Hospital, Albany, N. Y.

Dr. Kate Daum is making a child health survey in the families of Beaver County, Pa., for the Trustees of Mother's Assistants of Beaver County.

NEW YORK DIETITIANS MEET

The monthly meeting of the New York Association of Dietitians was held April 23 at Bellevue Medical College, New York, N. Y. Dr. William Parkes, director of laboratories, Bureau of Health, New York City, spoke on "Public Health" and gave concrete examples of toxins and anti-toxins, the methods of preparations, use, and their reactions upon individuals. Sally Lucas Jean presented some of the work of the Child Health Bureau, how Health is taught the child in school, how it is then carried into the home and how presentable health is made to the child by plays and slogans.

We must not try to write the laws of any one virtue, looking at that only. Human nature loves no contradictions, but is symmetrical. The prudence which secures an outward well-being is not to be studied by one set of men, whilst heroisms and holiness are studied by another, but they are reconcilable. . . The proper administration of outward things will always rest on just apprehension of their cause and origin; the good man will be the wise man, and the single-hearted, the politic man.—*Ralph Waldo Emerson in "Prudence."*

OCCUPATIONAL THERAPY AS DEVELOPED IN THE NATIONAL HOME FOR DISABLED SOLDIERS*

BY MARY E. SHANKLIN, DIRECTOR OF OCCUPATIONAL THERAPY, NATIONAL MILITARY HOME, OHIO.

THAT the value of organized occupation for the handicapped is not altogether a modern conception in the National Home for Disabled Volunteer Soldiers is evidenced by the fact that soon after the establishment of the first of these homes for the care of the disabled veterans of the Civil War, such industries as shoemaking and furniture making were introduced into certain branches of the home. This was done with the evident purpose of offering a vehicle for assisting the disabled in making at least a partial economic adjustment. This work was discontinued after a time, but the fact that these industries were instituted even for a brief period, indicates that at that early date in the life of the home there was a realization of the need of some systematized form of motivation for permanently disabled men.

However, it was not until after occupational therapy had proved its value as a remedial measure in the hospitals of the army during the World War that it had its beginning as an organized part of the medical treatment in the hospitals of these homes.

When the hospitals of this service were reorganized and enlarged, and certain of the homes were converted into sanatoriums for the care of the disabled World War veterans, a limited number of therapists were employed, primarily for bedside occupations, the convalescent cases being cared for in the training centers established in these hospitals, under the auspices of the Federal Board of Vocational Education, prior to the organization of the U. S. Veterans' Bureau, to carry out the government's program of rehabilitation for the disabled veterans of the World War.

This arrangement continued until July, 1922, when the rehabilitation program in the hospitals of the National Home Service was taken over in its entirety by the home management. Since that time a systematic and earnest endeavor has been made to build up this form of treatment to the point of obtaining the maximum benefit from its use.

In formulating the policy to be followed in applying this remedial measure, two points have been strongly emphasized and strictly followed:

(1) That the purpose of the work shall be primarily therapeutic, any vocational value it may have being secondary or incidental. This, of course, does not preclude the possibility of linking up the work prescribed, for curative reasons, to a man's vocational needs.

(2) That the work in all its phases must be medically prescribed and guided. Realizing that the value of occupational therapy as a curative measure depends largely upon the care and precision with which it is prescribed, and the exactness with which these prescriptions are followed, this point of close medical supervision has been especially emphasized, and any deviation from this policy disapproved.

Standardization of the Work

In carrying out this policy, to attain the desired results, and place occupational therapy on an efficient working basis, a standardization of the work in this service was considered of primary importance. To accomplish this, especial emphasis has been laid upon the following points:

(1) The necessity of establishing a progressive program with carefully graded occupations, in regard to both the physical and mental activity involved, for all types of diseases to be treated.

(2) A careful analysis and classification of operations involved, in relation to their therapeutic value.

(3) The elimination of objectionable features, which experience had proved were detrimental to the curative value of the treatment.

(4) The desirability of emphasizing, wherever practicable, those occupations which are of economic and utilitarian value, and which may prove important factors in assisting the patient in his social and industrial re-adjustment.

Program for Occupational Therapy

To cover these points, and carry out this program of standardization effectively, a circular "Instruction, Occupational Therapy," was issued by the general headquarters office to all hospitals of the service having an occupational therapy section.

In accordance with the program outlined in these instructions, for occupational therapy purposes the patients to be treated have been broadly divided into three groups: (1) General medical and surgical cases; (2) mental and nervous cases; and (3) tuberculosis cases. The program for the work in general hospitals, beyond the purely diversional stage of ward occupations, has been planned along lines of progressive exercises for cardiac cases, and func-

*Reviewed and approved for publication by the Chief Surgeon.

tional re-education for orthopedic cases.

In developing the program for the mental and nervous cases, it has been the policy of the National Home Service that occupational therapy shall be considered in its broadest aspect in the treatment of these patients. The work is so organized that there is a regular progression through achievements constantly more difficult, from the lowest to the highest grade of occupations, in relation to the mental effort involved. The important factors in attaining the desired goal of the patient's social and economic adjustment, that is, the reawakening of the social instinct, and the re-establishing of good habits are always borne in mind.

In the program for tuberculosis cases, the occupations have been considered for both their psychological and physiological value, especial emphasis being laid upon the necessity of the program providing opportunities for carefully graded work, calling for a gradual increase in physical endeavor, which would supplement other exercises prescribed by the physician to aid in the hardening and building up of the patient's system.

Stages of Work

In developing the program for occupational therapy in each of these services, the treatment has been divided into three broad stages: (1) Individual occupational therapy (including habit training and bedside work); (2) group ward occupations, and (3) the curative workshop (including pre-industrial tests in the industries of the institution). It is emphasized, however, that while these divisions and their terminology are adopted for convenience in accurately grading the progressive steps, that the process of aiding in the recovery of a patient by properly selected and directed occupations, should be continuous and progressive from the bedside work until his discharge from the hospital.

Individual and Group Ward Work

Recognizing the fact, which experience has proved, that the later steps in rehabilitation can succeed only as ward occupations have aroused the patient's interest in industry, inspired the ambition and developed the application to carry on, the National Home Service has placed especial emphasis upon the necessity of a comprehensive and carefully worked out program for this phase of the work. In arranging this program of work for patients in bed, and those in the semi-ambulant stage a wide variety of occupations has been provided. In making this provision there was borne in mind the necessity of giving the physician opportunities of prescribing work suitable alike to the clinical needs of the patient and his temperamental and emotional needs for diversional and interest arousing occupations. Supervised reading has been used extensively in both general and tuberculosis services, in this first step in occupational therapy, with most satisfactory results, for it affords the physician the opportunity to direct closely and limit the patient's activities in this direction. It also offers the therapist an exceptional avenue of approach, and an opportunity to lead his thoughts, by carefully chosen subjects, away from morbid introspection into wholesome channels, and thus form the first link in his efforts toward recovery.

Generally speaking, the manual work provided in the program for group ward occupations varies but little in kind from that provided in individual occupational therapy, but this grade of work is definitely indicated in the program, not only for its value in offering opportunites for increased physical and mental endeavor, but also for its great value to many patients who need the inspiration of social contact and friendly competition.

The type of occupations approved for both individual and group ward work, of necessity, varies with the type of disease to be treated. In both bedside and group ward occupations for general hospital cases, the program has been developed largely for its diversional value, except in cases of stiffened muscles and joints, which require occupations involving definite types of corrective exercises.

In the program for mental patients occupational therapy for the individual is applied to those cases where intensive treatment is indicated as necessary to obtain quick results, and with cases which are so submerged that it is impossible to arrest their attention by methods employed in group work. In general, the only occupations possible of use with which this type of patient are those which require a minimum degree of concentration. This phase of the program is adapted also to the occupational needs of habit training classes for the deteriorated patients, where diversional occupations form an important part in the day's program. For this type of patient music and recreation, such as marching, ball playing and simple games have proved invaluable as interest-arousing factors, and in training in habits of attention, concentration, and coordination of mind and muscle.

The occupations approved for group ward work with mental cases range from the most mechanical operations to those requiring a moderate degree of concentration and application, and having a definite constructive value. The program is sufficiently flexible to allow the therapist opportunities for adapting each process to the patient's particular kind and degree of mental illness. Also at this stage, emphasis is laid upon outdoor group work of utilitarian and economic value to the institution, for certain patients for whom this type of work is more stimulating than the more sedentary occupations of group ward work.

In the program for individual or bedside work with tuberculosis cases, the occupations are graded from those diversions in which the patient takes only a passive part, on through the minor crafts requiring only a slight degree of physical effort. Such occupations as necessitate stretching of the pectoral muscles, improper posture, or, where the work is done on open wards the use of dampened materials, have been eliminated as far as possible from the list of occupations approved for this type of patient. When the patients have reached the semi-ambulant stage, and can work in groups on sun parlors or porches, then occupations requiring an increased degree of physical endeavor and application are given.

Curative Workshop Program

In developing the program for the curative workshop stage with all types of patients, this kind of work is only approved where it bears a progressive relation to ward work, in regard to both the physical endeavor and application involved. Also, believing that accomplishing work of real utilitarian value goes far in assisting the patient toward the desired goal of an economic recovery, a continuous effort is made to fit the program for occupational therapy at this stage in the program for institutional maintenance. Such work as furniture repair, both wood and reed, sign painting, rug weaving, broom making, gardening, poultry raising, radio, clock and typewriter repair have all afforded an opportunity for fitting the utilitarian work into the curative workshop program for all types of patients.

While at all stages in the application of occupational therapy the utilization of inexpensive and waste material is encouraged, during the curative workshop stage of the

program this point is definitely stressed, for experience has proved that not only can equally desirable therapeutic results be obtained from occupations utilizing these materials, but also the principles of thrift and economy, thus inculcated, may form an important factor in the patient's social and economic adjustment.

The program for the curative workshop in the general hospitals of the service is twofold in purpose, in that it offers an opportunity for the application of occupational therapy for functional re-education for orthopedic cases, and graduated exercises for cardiac cases. It has also been of value in affording at least partial rehabilitation for those permanently disabled cases, who are handicapped both physically and educationally from training beyond the type of occupations included in the curative workshop program.

In developing the program for the curative workshop and pre-industrial stage in the neuropsychiatric branch of the service, work of utilitarian and economic value has been strongly emphasized. Rug weaving, commercial basketry (splint and willow), broom making, woodwork, gardening and poultry raising are representative of the occupations employed for this type of patient. Also, in carrying out this program the fact has been borne in mind that many patients will always require custodial care, and therefore the training in the curative workshop in many cases is directed toward the patient's employment in the hospital, where he may often lead a contented existence, working under supervision in some useful and productive occupation within his powers. Side by side with the program for productive occupations for this type of patient, is that of recreations, which call for initiative, cooperation and individual responsibility. This program has been comprehensively developed with most satisfactory results in the neuro-psychiatric branch of the service.

With the pulmonary tuberculosis cases, when the patient has reached the stage in his progress toward recovery that clinical evidences of activity have subsided, and has become an ambulatory case, then it is considered of prime importance that the activities of the patient be directed along lines that will not only offer opportunities for a progressive increase in physical effort, but also that the working conditions will more and more approximate those which he will carry on after his discharge from the hospital.

The occupations provided for this stage of the program are divided according to the physical activity involved into three grades: (1) light, (2) medium, and (3) heavy, the patient being prescribed the grade of work which meets his clinical needs.

The program for the ambulatory cases under extended treatment consists of a graduated form of exercise included, usually, in the light and medium grade of work, the heavier type being used for the pre-industrial tests preparatory to discharge. In selecting the occupations for this program, emphasis has been laid upon those which offer possibilities for connecting the work, given for therapeutic reasons, with subsequent training for a vocation. The prolonged periods of treatment necessary with the majority of these cases offer an opportunity for laying a foundation for a definite economic and social adjustment. Classroom subjects have a place in the program for this type of patient, since the length of his stay in the hospital makes it possible for him to pursue certain lines of study to the point of benefitting educationally, and in many cases, vocationally.

The development of a more scientific application of occupational therapy to the patient's treatment at this stage has been especially marked in certain of the tuberculosis hospitals of the service. The application of the graduated form of exercise in the hardening process with tuberculosis patients has been used in all hospitals of the service caring for this type of patient, but the details involved in working out this program, of necessity, vary in the different hospitals.

In one hospital marked success has been obtained, and the patient's cooperation and enthusiasm aroused, by establishing an extended and separate program of treatment for a group of ambulant cases segregated in one building. By a system of monitorship this group is made practically a self-governing body. Not only do graduated exercises form an important part of this program, but the living and working conditions are made to approximate those of the outside world. Further, through the cooperation of the Red Cross, those patients discharged as arrested, are contacted, if possible, over two-year periods, the purpose being to continue their records as to physical and social adjustment on the outside, from the time of arrest of disease. Thus there is established as nearly an accurate record as possible of what percentage of patients of a given group actually make the grade after they are discharged as having received the maximum of hospitilization.

In another hospital, in addition to the program for extended treatment cases, schedules of work have been developed for: (1) Observation cases, and (2) apparently arrested cases preparatory to discharge. The chief point of difference in these schedules is the length of time they are prescribed. During the time the patient is prescribed this schedule of treatment he is under close medical supervision. Temperatures are taken after each period of work, and his reaction to each type of exercise carefully noted.

The program for observation cases consists of an intensive schedule of graduated exercises prescribed for a limited time, to test the patient's resistance and reaction to a given grade of exercise for a definite length of time, as an aid in determining the diagnosis. Manifestly it would be impossible in the limited time allowed for each grade of exercise in this program, for the patient individually to accomplish any constructive work. Therefore, the occupations chosen for this program are those which require little instruction, and, preferably, those which can be accomplished in groups. The fact that the occupations used for this program are largely those of economic and utilitarian value to the hospital has aided in impressing the patient that the work is given as a definite medical treatment, and not as a diversional pastime.

The program for apparently arrested cases, preparatory to discharge, is an intensive one of graduated exercises, on a twenty-day schedule of six hours per day. During this time, while the exercise element is of paramount importance, it is yet possible for the patient to accomplish creditable individual work, requiring some technical training.

The programs of exercises for these groups are as follows:

(1)

Type of patient: observation tuberculosis.
Exercise: graduated form
1. Light
2. Medium
3. Heavy

Light

Schedule: 1 day, 6 hours per day
Occupation: Woodworking; small bench work using motor-driven equipment,
Gardening; raking and planting seed, watering garden,
Feeding chicks, rabbits and guinea pigs.

(2)

Type of patient: pulmonary tuberculosis, apparently arrested.
Exercise: graduated form
1. Light
2. Medium
3. Heavy

Light

Schedule: 5 days, 6 hours per day
Occupation: Weaving, small loom.
Basketry, small type
Art metal work (etching)
Furniture painting
Typing and mimeographing
B'ue-printing.
Gardening: planting seed, wa-

Medium	tering garden Poultry: feeding chicks, tending incubator, gathering eggs.
Schedule: 1 day, 6 hours per day	**Medium**
Occupation: Woodwork: cabinet repair, hand planing on soft wood, furniture refinishing. Rug weaving Chair caning, using simple types of caning, Gardening: hoeing, transplanting and gathering vegetables Care of incubator, rabbits and guinea pigs.	Schedule: 5 days, 6 hours per day Occupation: Weaving, large loom. Basketry and caning, large type Metal work, hammered and pierced Woodwork, using motor driven equipment Gardening: raking, transplanting, gathering vegetables, tending hotbeds Poultry: care of poultry houses Care of rabbits and guinea pigs
Heavy	**Heavy**
Schedule: 3 days, 6 hours per day Occupation: woodwork, using hand tools, including brace and bit, screw driver, draw knife, and planing on hard wood. Hospital repair work Gardening: hoeing and spading, Mowing lawns and recreational grounds.	Schedule: 10 days, 6 hours per day Occupation: woodwork, using hand tools Furniture repair Fibre furniture making Hospital repair work Farm carpentry Gardening: spading, hoeing Mowing lawns and recreational grounds

Therapeutic Classification of Occupations

In developing the occupational therapy program for all types of diseases, it has been deemed essential that a uniform policy be adopted in regard to the proper application of the various types of work included in the program. Therefore a careful analysis has been made of the mental and physical activity involved in each operation, and this data classified in regard to type of disease and grade of patient to be treated. This compiled information has been distributed to all hospitals of the homes having an occupational therapy service, as an aid to the physician prescribing the work, in giving him the desired information in regard to the degree of activity involved in a given operation; and to the therapist, in assisting her in a more accurate and scientific application of the treatment prescribed.

Reports. The occupational therapy statistical reports approved for the use in this service, follow closely along the lines of the standard forms for reports adopted by the American Occupational Therapy Association. They are: (1) prescription occupational therapy; (2) daily attendance register; (3) daily absentee report; (4) clinical record; (5) administrative card. These reports have been found to cover adequately and comprehensively the field of occupational therapy activities.

Shops and Equipment. Adequate space and equipment to meet the physical requirements for developing the program for occupational therapy have been provided in this service. In the neuro-psychiatric sanatorium at Marion, Ind., a building has been erected for occupational therapy shops, which is modern and well equipped; also a gymnasium has been provided for physical exercises and recreational activities. In the tuberculosis hospitals provision has been made within the hospital buildings, usually the ground floor of one wing has been assigned to occupational therapy. In the general hospitals, shops have been provided either within the hospitals or in adjacent buildings.

Conclusions. While an earnest and continuous endeavor is being made toward standardization and a more scientific application of the work, by all hospitals in the National Homes, having an occupational therapy service, yet it is realized that this form of treatment is only in its infancy, and that the future holds broad opportunities for growth and development in this service.

After observing the growth of occupational therapy, not only in the National Homes, but also in other services, it is the opinion of the writer that two requirements stand out as essential to the achievement of the desired results: First, that the medical profession must carefully study occupational therapy from its inception, and after such study be convinced that it is a service based on sound scientific, therapeutic principles. Consequently, cases must be studied conscientiously, with a view to prescribing occupational therapy where therapeutically needed, as any other aspect of the case would be studied, whether medical or surgical. Second, that every occupational therapist applying the treatment, must be imbued with an understanding and whole-hearted appreciation of the therapeutic value of the work, and with a full realization of the fact that it is the privilege and responsibility of each one to contribute his or her quota of effort toward improvement in methods of treatment. It is only by the constant and concerted efforts of all who have a part in the application of the treatment that we may hope to attain, in the National Home Service, the desired goal of the maximum benefit to the patient, by hastening his recovery from disease, and assisting in overcoming that most deplorable condition, invariably following prolonged absence of occupation, which has been aptly termed "industrial invalidism."

NEWS ITEMS

A local meeting of the California State Association of Occupational Therapy was held in Los Angeles on the evening of March 19, when it was decided to meet once a month at the Chateau Cafe, for dinner at 5:30, on the second Thursday. Plans were made to have two speakers each evening to talk on different subjects of interest and help to occupational therapists. At the following meeting, April 9, the speakers scheduled were Colonel James Mattison, commanding officer of the National Soldiers' Home, Sawtelle, and Mr. Holland, head of the Los Angeles county hospitals.

The San Francisco monthly meeting of the association was held the afternoon of April 4 at the St. Francis Hotel, Miss Florence Cummings, head of the social service department of Lane Hospital and associate professor at Stanford University gave a very interesting talk on her work not only in that state but in other parts of the country. Following Miss Cummings' address, three of the active members gave informal talks and demonstrations of projects popular in their hospitals. Miss Barbara Balfour, in charge of the work at the Arroya Sanatorium, Livermore, showed some charming designs made of colored paper cut into various shapes and grouped attractively. Her work is entirely with tuberculous patients, who find paper cutting very easy and interesting work for them. These designs, when made, could be used to put under the glass in reed trays where they lend charming effects. Miss Elsie Geerts, U. S. Veterans' Hospital, Palo Alto, demonstrated the making of yarn dolls which, she said, was very popular with neuro-psychopathic patients. A grey neutral yarn was used as the foundation and bright colored yarns, which delighted the patients were used as a finish for the garments. Miss Milward Holden, chief aid, Lane Hospital and U. S. Marine Hospital, San Francisco, showed some clever toys made by the sailors and some bags woven on canvas made by other patients.

A night letter was read from Miss Sarah Haseltine, one of the board members on duty at the U. S. Veterans' Hospital, Camp Kearny, saying that she had addressed three women's clubs in San Diego in the interest of occupational therapy and expected to meet there with the craft teachers of the public schools.

Miss Barbara Balfour is keeping occupational therapy alive at the Arroya Sanatorium not only by teaching it but by writing several articles on the subject for the

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hospital paper and has talked to the patients concerning it, over the radio.

Miss Milward Holden is attracting a great deal of attention in San Francisco with the toys made by her sailor patients at the Marine Hospital. The San Francisco papers have had articles concerning the work and shown pictures of the patients at work. Miss Holden designs the toys (she is an expert wood carver herself) and the sailors, with their natural fondness for whittling, manufacture most unusual and well-made articles. Their sail boats are a work of art. At present a great number of these toys are on sale for three days at two of the leading department stores in San Francisco, The White House, and City of Paris. The toys are so well made and so popular that the orders cannot begin to be filled, even though hundreds of dollars worth have been sold in a short time.

Maryland

The following officers have recently been elected to the Maryland Association:

Mrs. Marshall L. Price, director O. T., Sheppard & Enoch Pratt Hospital, president; Miss Katharine Brady, vice president; Miss Emily West, secretary; Miss Nell Berry, treasurer. The program committee is composed of Dr. William Rush Dunton, Jr., and Miss Lucy Gilpin. It was suggested that instead of holding regular monthly meetings of the society, it would be well to have fewer meetings and attempt to make them larger. In accordance with this idea, on March 12, a joint meeting and supper of the Baltimore Handicraft, members of the Washington Society of Occupational Therapy and the Maryland Occupational Therapy Association was planned at the Dutch Tea Room in Baltimore. Mrs. Eleanor C. Slagle, New York, N. Y., gave us a most inspiring talk. Dr. F. H. Allen, psychiatrist, Phipps Psychiatric Clinic; Miss Alberta Montgomery, chief therapist, Walter Reed Hospital; Arthur Limerick, president, Baltimore Handicraft, and Alon Bement, director, Maryland Institute of Art read papers. Eighty-six persons were present.

Members of the Maryland Occupational Therapy Association met in Washington, April 22, with the District Society.

Massachusetts

The Boston School of Occupational Therapy announces wtih pleasure that Mrs. Charles A. Rheault (Rosamond Bradley) has joined the board of directors. The faculty and curriculum of the school remain practically the same. There are at present twenty-four students enrolled representing many different states besides Canada, England and Bermuda.

The Boston School in answer to the national call for funds has pledged $100 to the A. O. T. A.

The District and the Curative Workshop Department continues to grow and is appreciated more than ever as an invaluable part of the training school.

The Public Health Committee of the Massachusetts State Department of Nurses' Clubs conducted a session given over to the subject of mental hygiene and occupational therapy. Over two hundred were present and a great deal of enthusiasm for occupational therapy was aroused.

Colorado

Miss Mable A. M. Bond, formerly head occupational therapist for four and one-half years at the Philadelphia Hospital for Mental Diseases, has gone to Denver, Colo., showed a variety of therapeutic work and crafts and to organize the occupational therapy department of the Colorado Psychopathic Hospital, Denver.

Connecticut

The policy of the Connecticut association is to have special meetings from time to time in connection with various state organizations, in order to give the members the benefit of such programs. If possible, a speaker will be engaged for such occasions.

The Connecticut Conference of Social Work was held at Waterbury, April 26-29, with occupational therapy as the main feature of the meeting. On April 27, Mr. T. B. Kidner gave an address on "Occupational Therapy" and Mrs. Eleanor Clarke Slagle gave an illustrated talk on "Occupational Therapy in State Hospitals."

On April 29, a round table was held on "The Place of the Occupational Therapy Workshop in the Community."

An interesting exhibit was also shown of occupational therapy which, while small, was so well selected that it eliminated the usual overcrowded tables of work which do not feature the case record and therapeutic achievement. Six hospitals were asked to send work, as follows: two state hospitals for mental cases; one private tuberculosis sanatorium; one general hospital; one private sanatorium for nervous cases; one private occupational therapy workshop.

Each sent one chart with a case history as follows:

(1) Woman, high-grade and man, low-grade; (2) average case showing economic phase; (3) orthopedic case (crushed hand); (4) average case; (5) heart case (treatment beginning in hospital and followed in the shop outside). Below each chart one or two pieces of work done by the patient illustrated progress, etc.

A community meeting was held at Hartford May 8. The health committee of the council of social agencies was the hostess of the day. Miss Kathryn Root, president, Connecticut Occupational Therapy Association, gave a talk on the state society and its plans.

Pennsylvania

Miss Helen Louise Lynch, former chief occupational therapist at Retreat Mental Hospital, has resigned to be married.

The Philadelphia Occupational Therapy Association has held three interesting meetings this year. At the first meeting, held at the Philadelphia School of Occupational Therapy, Dr. William Stroud, secretary of the Association for the Prevention and Relief of Heart Disease, gave a talk on occupational therapy for heart cases. At the second meeting, also held at the school, Dr. H. A. Pattison, supervisor of medical service, National Tuberculosis Association, spoke on occupational therapy for the tuberculous. Dr. Charles J. Hatfield, director, Phipps Institute, was present and introduced Dr. Pattison. The third meeting was held at the Pennsylvania Hospital in the occupational therapy workshop. Miss Sallie B. Tannahill of the art department, Teachers College, Columbia University, New York, N. Y., gave a valuable demonstration of block printing and exhibited many examples of the work done by herself and her students.

Wisconsin

The Wisconsin association held a benefit bridge party on April 25, to raise the money for their $100 pledge to the American Occupational Therapy Association.

The Wisconsin Association of Occupational Therapy held a banquet on March 16 in honor of President T. B. Kidner who was visiting the Milwaukee association.

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Serve JELL-O with fruit as Jell-O Macédoine

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America's most famous dessert

MEETINGS, CONVENTIONS AND CONFERENCES

HOSPITAL ASSOCIATION OF ILLINOIS HOLDS SECOND CONFERENCE IN CHICAGO

A LARGE delegation of more than 100 hospital executives from all parts of Illinois attended the second annual conference of the Hospital Association of the State of Illinois held at the Hotel La Salle, May 1 and 2, 1925. The opening meeting was taken up chiefly with three papers dealing with different phases of hospital administration. "Fundamental Principles Involved in Efficient Hospital Organization," was the subject of a paper presented by Mr. Clarence H. Baum, superintendent, Lakeview Hospital, Danville, who outlined methods for reaching the goal of efficient hospital administration.

The subject of "Monthly Reports to Trustees," was handled by Mrs. Valentine R. Hoener, superintendent, Chicago Memorial Hospital, Chicago, who explained and exhibited a number of monthly reports which were distributed among the delegates.

Methods of Financing Hospitals

"Financing Hospitals" was the subject of a paper by Mr. J. W. Meyer, manager, Aurora Hospital, Aurora, who suggested a number of methods for financing, such as community drives, enlisting the interest and cooperation of churches, clubs, and civic organizations and the use of field secretaries in collecting funds for hospital building and maintenance.

The final paper of the session, "The Organization and Administration of a School of Nursing in Hospitals under One Hundred Beds," was read by Mrs. Nan H. Ewing, principal, Ravenswood Hospital school for nurses, Chicago, who directed attention to the problem which the small schools face in competition with the larger ones, and advocated affiliation of the smaller with the larger schools in the community as a possible solution.

The Friday afternoon session consisted of a paper on "Hospital Economies," read by Miss Macie N. Knapp, R.N., superintendent, Brokaw Hospital, Normal, and a round table on administration problems conducted by Dr. Paul W. Wipperman, superintendent, Decatur and Macon County Hospital, Decatur.

Miss Knapp presented a thorough outline of what small hospitals can do in the way of effecting definite economies, from the careful selection of employees to the accurate checking of supplies. She showed concretely what the hospital could save in reducing the cost of plumbing and repair of machinery by proper care of such equipment, what might be saved through an orderly linen room, through the exchange system of supplies, through an efficient central diet kitchen with a careful inspection of garbage cans, and in laundry work by the hospital's doing only the ironing in the institution and by having the washing done outside the institution.

What is Best Size for Board of Trustees

The round table opened with the question of what size of board of trustees functions most satisfactorily. The discussion was opened by Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, who favors the board of twenty-four members working alternately in four sections of six each. The remainder of the discussion on this topic resolved itself into the question of whether the medical staff should have representation on the board and whether the board should be open to women. The consensus of opinion of the meeting was in favor of representation of the medical staff and against the exclusion of women members.

The discussion on how to improve the quality of case records was opened by Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, who left the impression that the quality of case records is largely dependent upon the standards of the medical staff of the individual hospital, and that improvement can come only through cooperation of the entire staff.

The proper method of determining the cost per patient day, the daily census of patients and the annual death rate, gross and institutional, was discussed by Mr. Clarence H. Baum, superintendent, Lake View Hospital, Danville, who directed attention to the methods approved by the American Hospital Association in bulletins numbers 50 and 59, which offer a basis for uniform methods of determining these statistics.

The subject of the best method of handling complaints from patients was discussed by Miss Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, who summarized the best methods of handling complaints as follows: (1) rectifying the mistake with the patient; (2) keeping the same mistake from occurring again.

Efficiency in the distribution of supplies was discussed by Mr. Ralph Hueston, superintendent, Galesburg Cottage Hospital, Galesburg, who strongly advocated the use of the requisition system and stressed the need for careful purchasing, receiving and recording of supplies.

How a hospital may stimulate more community interest in the annual report was discussed by Mr. Matthew O. Foley, managing editor, *Hospital Management*, Chicago, who presented an analysis of an annual report from

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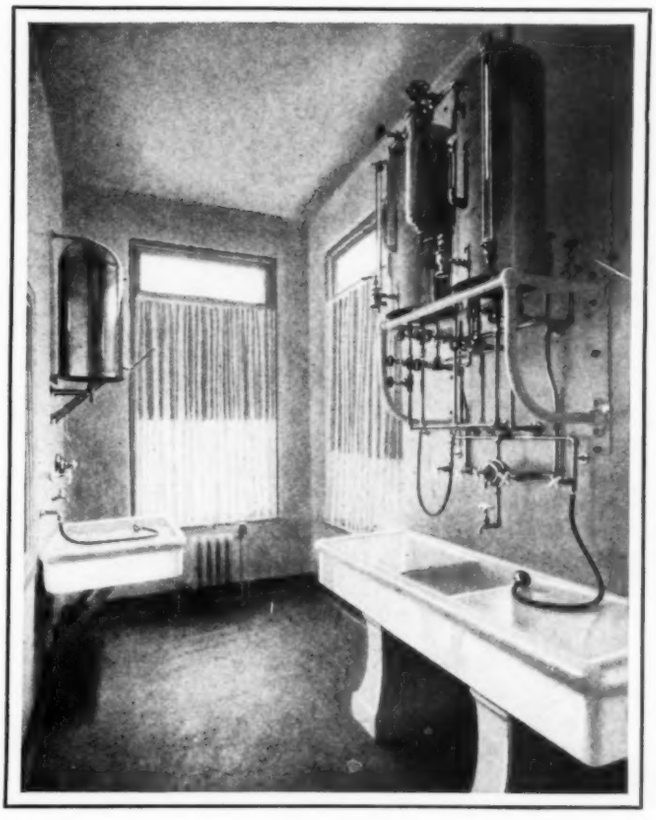

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the hospital view-point and that of the layman, the latter being based on the comments of a representative of the press. The analysis brought out the difference between what constitutes a good report from the standpoint of statistics in contrast to that of human interest.

The subject of how the busy superintendent can get the most out of the various hospital publications and how he can interest his trustees in them was handled by Mr. Stanley R. Clague, circulation manager, THE MODERN HOSPITAL, Chicago, who outlined a method of circulating the magazines through the hospital in such a way that the different department heads have a specified time for studying the contents. He advocated a system of study of the leading problems brought out in the different magazine articles by a series of questions for conferences of the superintendent with the department heads, and by calling the attention of the board of trustees to the articles which are of interest to its members.

Whether or not the superintendent of the hospital should attend the meetings of the board of trustees and medical staff was discussed by Mr. George S. Hoff, Danville, who believes that the superintendent should attend meetings and have all the privileges of the board except that of voting.

A business session completed the afternoon's program. The following officers for the coming year were nominated and elected by a motion calling for a unanimous ballot from the secretary: president, Mr. George S. Hoff, Danville (reëlected); first vice president, Dr. Paul W. Wipperman, Decatur; second vice president, Miss Ida B. Venner, R.N., superintendent, Passavant Memorial Hospital, Jacksonville; secretary-treasurer, Mr. Clarence Baum, Danville (reëlected); and trustee, Dr. M. T. MacEachern, Chicago.

Banquet, Addresses and Motion Pictures

The conference banquet was held in the grill room, Hotel La Salle. The program consisted of the introduction of guests of the association, two addresses and three motion pictures.

"The Hospital of Tomorrow" was the subject of the address by the Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis., who briefly traced the development of the hospitals in this country to the present "golden age," and warned against hospitals becoming too institutionalized and thereby losing sight of their true mission.

"The American Hospital Association" was the subject of the address by Dr. William H. Walsh, executive secretary, American Hospital Association, Chicago, who sketched the definite projects before the association at the present time. He enumerated as the aims (1) Closer contact with the hospitals of the entire field through an adequate number of fields representatives; (2) a placement bureau which will be able to offer extensive service to members; (3) promotion of needed legislation through a national committee with a representative in each state; (4) the development of present activities including increased membership.

An educational talk on the sanitary features of monel metal in hospital equipment, was given by Mr. Dickinson, Steel Sales Corporation, Chicago, accompanied by a motion picture. The program ended with two motion pictures "How the Fires of the Body are Fed," and "Nursing our Neighbors."

Saturday morning's program opened with a talk, "Keeping up with the Advances of Hospital Administration," by Mr. E. I. Erickson, superintendent, Augustana Hospital, Chicago, who told of his personal experiences in visiting various hospitals for the purposes of study and his course in hospital administration at Temple University, Philadelphia, Pa.

Explains Value of Accurate Records

"Overcoming the Difficulties of Case Recording in Small Hospitals" was the subject discussed by Dr. Carl E. Black, surgeon, Passavant Memorial Hospital and Our Savior's Hospital, Jacksonville. Dr. Black showed that personal responsibility is the prime factor in maintaining adequate records in small hospitals, and cited instances in court procedures to show the necessity of making and keeping accurate and complete records of cases. He advocated having an historian and a stenographer to take the doctors' notes. This subject was also discussed by Miss Zula Morris, former record librarian, Butterworth Hospital, Grand Rapids, Mich.

"An Efficient Dietary Service in a Fifty Bed Hospital" was discussed by Miss Della De Long, superintendent, Silver Cross Hospital, Joliet, who described the operation of the semi-central dietary service of her hospital. She showed the importance of careful requisitioning of supplies and the inspection of garbage cans and employees leaving the hospital.

The round-table discussion unfinished on Friday was then resumed and attention was centered upon the subject of how the hospital can best function in the health education of the community. The subject was discussed by Dr. M. T. MacEachern who outlined the functions of the hospital in relation to the community in the training of interns, nurses, and lay workers to disseminate information; in the extension of health education through social service; in preventive work through the out-patient department; in special services such as diagnostic clinics and clinics for periodic examinations.

Round Table on Nursing Problems

The concluding session of the conference, Saturday afternoon, was held at the Ravenswood Hospital, following a luncheon on the roof garden of the hospital. The session was devoted to a paper and round table on nursing problems. "The Standardization of Training Schools" was the subject of the paper by Miss Laura R. Logan, dean, Illinois Training School for Nurses, Chicago, who made a plea for a thorough preparation for the suggested grading plan which aims to set up uniform standards for schools of nursing.

The round table conducted by Miss Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, unearthed many timely problems of nursing education. One of the interesting discussions centered around what holidays and sick leave should be granted to undergraduates. The discussion showed that almost half the total number of institutions represented gives but two weeks while but one-fourth allows a month.

Another interesting discussion centered around the adjustment of the problem of strained relationships which often arise between hospital authorities and graduate nurses on special duty. The following methods were suggested for overcoming this difficulty: personal rather than group conferences; a fixed time each week for a conference between nurse and superintendent of nurses; more thorough discipline of undergraduate nurses.

The third annual institute of the Iowa State League of Nursing Education was held in cooperation with the University of Iowa at Iowa City, Ia., May 7 and 8, 1925.

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TIME to calm your patients, to remove them from the threatened vicinity, to safeguard them from smoke, noise, flames. Yet, at all ordinary times, Pyrono's finish is homelike in the familiar beauty of the real wood with which it is covered.

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NEW JERSEY HOSPITAL ASSOCIATION HOLDS ANNUAL MEETING AT NEWARK

THE New Jersey State Hospital Association held its annual conference at the Academy of Medicine, Newark, N. J. May 8, 1925. A well-balanced program, beginning with the executive conference at 10 a. m. and ending at 11 p. m., was presented before the one hundred delegates in attendance.

The opening address, by Dr. Gordon K. Dickinson, New Jersey Medical Association, on the subject of "Some Hygienic Methods of Treatment That Should be Used in Hospitals—Often Neglected," explained the importance of light in the treatment of diseases, a neglected essential in many hospitals, particularly in the treatment and cure of tuberculosis in various forms, in all classes of patients. Tuberculosis in children is most susceptible to this treatment which, of course, must be applied in a scientific manner.

Standard Fee for Compensation Cases

The discussion of Dr. Dickinson's paper, by Henry C. Wright, hospital consultant, New York, N. Y., set forth the importance of proper hospital ventilation as an essential adjunct to the success of the light treatment for the patient's ultimate recovery.

"Compensation and Its Relation to the Physician, the Hospital and the Injured," was the subject of a paper by Dr. Andrew McBride, commissioner of labor, state of New Jersey, which dwelt on the excessive charges of the surgeon and hospital for the treatment of injured employees, an evil that has sprung up with the passing of the compensation statutes. It is so abused and alarming that the insurance companies are seriously considering the maintenance of their own hospitals for the treatment of the employees of their assured. The act, as explained by the doctor, is a splendid and most humane one and, if the hospitals were to interpret it correctly and abide by its provisions, a more satisfactory result would be forthcoming for all parties concerned. The discussion, which followed this paper, established the fact that the interests of all hospitals could far better be conserved if a standard fee was set for the treatment of all compensation cases. The law sets forth, fully and concisely, just what charges are allowable. But many of the hospitals in the state are not treating compensation cases, according to the proper interpretation of the law, which, if properly applied, would, in many instances, be favorable to the maintenance of their liability cases.

Principles of Hospital Planning

The afternoon session was opened by an address of welcome and a paper, "A Concrete Application of the Principles of Hospital Planning," by Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, N. Y., who gave a thorough description of hospital construction and planning. A set of plans, which he exhibited and explained, exemplified the importance of correlation of all departments to obtain the utmost efficiency in modern hospital building.

"Some By-Products of Hospital Activities," was the subject of a paper by Dr. Joseph C. Doane, president, Pennsylvania Hospital Association, Philadelphia, Pa., who dwelt upon the economic importance of the hospital, as a national and state asset, and the growth of the hospital throughout the world in the last half century.

He also stressed the importance of the teaching hospital, not in the restricted sense of the word as applied to those institutions directly connected with medical colleges. He feels that every hospital of ten or 500 beds, should be in a position to offer to nurses, interns and staff the advanced and up-to-date technique for the treatment of all classes of cases.

Emphasis Laid on Standardization

A paper on "Some Phases on the Problem of Obtaining Student Nurses," was presented by Miss Marsa R. Koerner, R. N., superintendent, Bayonne Hospital and Dispensary, Bayonne. The shortage of nurses, particularly in cities of industrial centres, was commented on, and the most practicable method of coping with the situation was discussed. The practicability of establishing a course of training for nursing aids was presented by Miss Koerner, as a consideration to offset the dearth of pupil nurses.

Dr. Allan Craig, representative of the American College of Surgeons, Chicago, Ill., discoursed on the subject of "A Problem of Hospital Standardization," setting forth the importance of a universal standard among hospitals, as outlined by the American College of Surgeons, and the benefit derived by both patients and hospitals from such standardization.

Dr. Louis I. Harris, director, bureau of preventable diseases, Department of Health, New York, N. Y., gave a resumé of the work being accomplished in the prevention of disease in that city. The treatment, disposition, and handling of contagious diseases along modern methods was ably presented.

Dr. E. K. Sprague, senior surgeon, U. S. Public Health Service, in an illustrated lecture, presented conditions as found and analyzed by the U. S. Government.

Round Table on Nursing Problems

The round-table discussion was in charge of Mr. W. C. Lyon, superintendent, Mercer Hospital, Trenton.

The status of nursing in the State brought forth considerable discussion as to whether the educational requirements or other agencies, beyond the control of the hospitals are responsible for the shortage of nurses.

One superintendent felt that the educational requirements were detrimental to obtaining pupils in industrial cities. While he was in favor of high nursing standards, he believes, that since the patients in the hospital are the first consideration, if the student nurse with the high school requirement is not obtainable, then other young women, such as aids, attendants, must be admitted to the hospitals and trained. The situation, in the opinion of this superintendent, is very serious. He intimated that his hospital would adopt these measures, if the nursing situation continued in its present unsatisfactory condition.

The evening session was of a social character. The Rev. Father John Quirk and Hon. David I. Kelly delivered addresses, followed by music by a local quartet.

The officers for the coming year are: President, Dr. Paul Keller, superintendent, Newark Beth Israel Hospital, Newark; vice-president, Dr. Samuel B. English, superintendent, Glen Gardner Sanitorium, Glen Gardner; secretary and treasurer, Mr. Thomas R. Zulich, superintendent, Paterson General Hospital, Paterson.

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ALABAMA HOSPITAL ASSOCIATION HOLDS SECOND MEETING

The second annual meeting of the Alabama Hospital Association was held at the Axis Club, Birmingham, April 22, in the form of an informal luncheon. The address of welcome was given by Dr. J. D. Heacock, Birmingham, president of the Alabama State Medical Association. Response was made by Dr. Byron Bruce, president, who made a plea for increased membership in order to bring about through cooperation a greater efficiency in the management of hospitals throughout the state. He laid special stress on the need for training of hospital executives.

An address on the teaching of public health nursing in hospitals was given by Miss Elizabeth La Forge, director of public health nursing, Birmingham. Miss La Forge strongly urged a closer relationship between theoretical training and practical work so that nurses may correlate illness in private homes with community health.

Miss Linna H. Denny, secretary, State Board of Nurse Examiners, who spoke on the subject of state registration, insisted that the educational standards for nurse training should be the completion of high school work. She urged superintendents not to permit student nurses to go out on private cases, as many of them are doing, as it obviously interferes with the classwork necessary to thorough preparation, and is the cause of many students failing to pass the state board examinations. She also urged affiliation of the smaller schools with the larger schools of the state.

A talk on tuberculosis nursing was given by Miss Bertha Clement, director, tuberculosis nursing in hospitals, Birmingham, who believes that the training schools have a duty to perform for public health in giving students a more practical knowledge of tuberculosis through affiliation with tuberculosis sanatoriums. She encouraged the use of the ten-lecture course in the curriculum of the schools of nursing of the state which have for some time included tuberculosis nursing. Miss Clement's talk was followed by a paper on legislation in the schools of nursing in Alabama by Mrs. I. S. Inscor, Dothan, who brought out the need for inspection of the schools of the state. The paper was discussed by Miss Helen MacLean, president of the state board of examiners.

The following officers for next year were elected at the business meeting: president, Dr. F. G. Du Bose, Selma; first vice president, Dr. V. J. Gragg, Clanton; second vice president, Dr. Byron Bruce, Opelika; secretary, Miss Helen MacLean, Jasper, (reelected); and treasurer, Mrs. I. S. Inscor, Dothan. The board of trustees includes Drs. B. L. Wyman, Birmingham; A. M. Carmichal, Fairfield; J. U. Ray, Woodstock; Carry Moore, Talladega; C. L. Salter and F. H. Craddock, Sylacauga. It was decided that the next meeting of the association would be held in Mobile, in 1926.

UTAH ASSOCIATION MEETS

The annual meeting of the Utah Hospital Association held April 29 at Salt Lake City, centered around the problems of relationship of doctor and nurse in the hospital. In his presidential address, Mr. W. W. Rawson, Thomas D. Dee Memorial Hospital, Ogden, called attention to the fact that all the hospitals of fifty beds or over in the state are members of the American Hospital Association, and that seventy-five per cent of these hospitals had representatives at the A. H. A. Buffalo conference. He said that ten of the twenty-nine hospitals of the state of less than fifty beds do not have graduate nurses in charge and recommended that the state nursing association and the hospital association work hand in hand in securing an adequate number of trained nurses. Accordingly, the association extended an invitation to the state nurses association to assist the hospitals in this work. The invitation was accepted and committees were appointed to cooperate in making uniform rules governing graduate nurses in hospitals and uniform curricula for the schools of nursing.

Miss Helen Wicklund, Holycross Hospital, Salt Lake City, presented a paper on "What the Hospital Expects of the Nurse" which was followed by a paper on "What the Nurse Expects of the Hospital," read by Miss Alice Hubbard, St. Mark's Hospital, Salt Lake City. At the evening session Dr. Joseph R. Morrill, read a paper on "The Benefits Which May Be Attained Through Closer Cooperation of the Medical Staff and the Nurse."

One of the special features of the meeting was the representation of an ideal staff meeting staged by members of the staff of the Thomas D. Dee Memorial Hospital.

The following officers were elected for next year: president, Mr. W. W. Rawson (reëlected for the fifth time); first vice president, Miss Mary Hales; second vice president, Dr. J. J. Galligan; secretary, Miss Margaret Ingersol, and treasurer, Mr. Heber Grant.

CONNECTICUT ASSOCIATION MEETS

The annual meeting of the Connecticut Hospital Association was held on April 25 at Sterling Hall, Yale Medical School, New Haven.

Dr. T. E. Reeks, president of the association, presided. There were forty-eight present. The program was as follows:

The morning session was taken up with the reading of minutes, unfinished business and reports of committees, new business, and round table.

Upon the invitation of Dr. W. C. Rappleye, superintendent, New Haven Hospital, a luncheon was held from 1:00 to 2:00 o'clock at which "State Appropriations to Hospitals," was discussed.

The speakers were: Mr. Charles A. Russell, Middletown; Dr. L. A. Sexton, Hartford; Dr. W. Rappleye, New Haven; Mr. Charles Lee, Waterbury, and Mr. John Wadhams, chairman, State Board of Finance and Taxation.

After luncheon the meeting was called to order by the president, Dr. Reeks.

The following new members were accepted: Mr. Thomas Bowen, secretary, Hospital Board, Danbury; Miss Nora Creagh, night supervisor, Danbury; Mrs. Chester Brush, member, board of management, Danbury; Miss Mary E. Shields, superintendent, Rockville City Hospital, Rockville; Miss Grace B. Beattie, superintendent, Johnson Memorial Hospital, Stafford Springs.

The hospitals in the state of Connecticut have been supported over a period of years by grants from the state which enable them to maintain a high standard in efficiency. It was the consensus of opinion that Connecticut had been generous toward its hospitals in this way, and that it was because of this support for a number of consecutive years that the hospitals had maintained a splendid standard.

While the lower forms of social conduct are the direct issue of the prompting of instinct, the higher forms of social conduct, which alone are usually regarded as moral, involve the voluntary control and regulation of the instinctive impulses.—*McDougall.*

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Space costs money. Save both by using a Simplex Unit.

The Simplex Unit gives the patient wheel chair comfort plus.

No need to ask where to put it when not in use. It can be hung in a closet.

Shipped in strong fibre carton, 32x25x5 inches, so small it can be carried in train, trolley or auto.

The Simplex Wheel Chair Unit, with table top and standard in place.

SIMPLEX WHEEL CHAIR UNIT

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

EQUIPPING THE PRIVATE ROOM

BY WILLIAM O. RICE, M.D., RHODE ISLAND HOSPITAL, PROVIDENCE, R. I.

THE following is a description of a typical room at the Jane Frances Brown Building for Private Patients, Rhode Island Hospital, with particular emphasis on equipment.

The room is practically twelve feet square, nine feet high, with one window six feet four inches by four feet, the window sill twenty-six inches from the floor. In the wall opposite the window there is a clothes closet opening into the room and a door leading into a corridor. The third wall of the room is blank and in the wall opposite are two doors, one leading into a bathroom, the other into a toilet room. The floor is of cement base covered with green battleship linoleum, except for a terrazzo base of four inches around the entire room, extending upwards as a dado for six inches. The walls are painted French grey, a color which is very pleasing and restful. The ceiling is white, and in the center the electric fixture is placed. This consists of a cluster of two lights enclosed in a cut-glass globe and controlled by a switch placed near the door opening into the room. One light is a twenty-five watt lamp which can be used as a night light or in conjunction with the other, a fifty watt light, when a brighter illumination is desired.

The clothes closet is recessed into the wall seventeen inches deep, is four feet in width by six feet high and has a shelf five feet from the floor. This floor is made of cement and is raised seven inches from that of the room. The doors to the closet are double, panelled and painted a mahogany color to correspond with the other doors in the building. In this closet are hooks for patients' clothes, blankets for the bed, enameled ware for the room, such as pus basins and foot-tub. Here are also kept, when not in use, a wooden footstool, a folding wooden food table and a folding wooden "over the bed" tray table.

One of the private rooms of the Jane Brown Memorial Building, Rhode Island Hospital.

A private room showing arrangement of tray service and other typical equipment.

This over the bed table is fourteen inches high, thirty-two inches long and twelve inches wide. It is made with folding legs at each end, which when set up fit inside the rails of the bed, thus making a rugged table stretching over the patient's chest or abdomen. On it food can be placed, games played, letters written or books placed. With its varied uses it becomes an important part of the equipment.

The door to the room is three feet six inches wide by six feet eight inches high, the upper half fitted with opaque glass and a green holland shade. Just over the door is placed a transom nine inches in height made up of four small panels of opaque glass.

The bathroom is five feet long, five feet wide and nine feet high, and so arranged that it may be used as a con-

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necting bathroom between rooms. It contains a bathtub flush with the walls of one side of the room and built into the white tile of the floor. This room also has fitted to the walls a towel rack and a handrail which patients can hang on to when getting in or out of the tub. The toilet room is six feet long, two feet seven inches wide and nine feet high with a small window. It contains a lavatory and a toilet with a flushometer valve. There is also fitted to the wall a mirror, towel rod and glass shelf.

The furniture in this typical patient's room consists of a bed, bedside table, one adjustable reading light, two straight Windsor chairs without arms, one upholstered wing chair, one reading table, one movable three-piece screen, a dresser and wall mirror. Except for the wing chair, the furniture is all painted French grey with a delicate narrow line of purple to match the color of the walls.

The bed is not of the usual institutional pattern, but rather such as one would find in a well-furnished home. It is equipped with five-inch, rubber-tired castors, adjustable gatch spring and adjustable extension rod for irrigating can which is placed between the foot of the spring and the bed frame. At the foot of the bed, just beneath the spring there is a special mechanical arrangement fitted with a detachable crank by which a nurse can easily raise a patient into a sitting position, raise the knees independently of the shoulders, or raise the patient into a Fowler's position.

The bedside table is square with a glass top, one drawer and one shelf. On the top is kept a tray containing a glass and vacuum watercarafe. On the shelf there is a small washbowl and pitcher made of tinted crockery, under the shelf there is attached the telephone box with a cord which fits into a wall outlet near the head of the bed. Besides this telephone outlet provision is made here for an electric fan, electric light and nurses' call buttons, one giving signals by lights in several places and the other a loud buzzer used in emergencies.

The reading table which is twenty-six inches high, ten inches wide and thirty-seven inches long has a kidney shaped top which enables the table to fit snugly against the upholstered wing chair and over the patient's knees. Convalescents find this table very useful at meal times; for writing; for holding books and for playing games.

The screen is made of three folding frames painted a mahogany color to match the doors and is equipped with washable aeroplane cloth. Also there are adjustable curtain rods to take up the shrinkage of cloth.

Between the bathroom and lavatory doors, backed up against the wall, is a dresser thirty-five inches long, eighteen inches wide and thirty-four inches high, with a glass top, made on straight lines. It has two large lower drawers and two small upper drawers side by side. Suspended from the moulding above this dresser hangs a framed mirror twenty-six inches high and eighteen inches wide.

In planning this room much time and thought were given, not only to modern hospital construction but especially to the convenience of patients and workers, to esthetic taste in the way of furnishing and to a departure from the institutional look.

A WHEEL CHAIR UNIT

The wheel chair unit, shown in the accompanying illustration, is adaptable to almost the whole range of chairs, but is designed particularly for use in connection with the comfortable rocker. In this the patient may sit upright while using the table, or, when tired, may recline comfortably, the chair being immovably locked at any angle.

The construction is light steel throughout, including table and footrest. The latter, however, is covered with heavy-grade cork linoleum. The swivels are provided with ball-bearings, and wheels with rubber tires warranted not to become loose.

In position the table is rigid. It is detached by raising the standard out of the socket in the footrest, and the top, detached from the standard, serves as a tray. As a tea, card, sewing, reading, or writing table, this feature contributes much to the comfort of the patient.

The unit may be carried as ordinary hand baggage on the train, street car or auto, and hung in clothes closet when not in use, without sacrifice of room.

As it is simple, compact, and portable, the unit will be found advantageous in case of lean appropriations, in congested quarters, small rooms, narrow halls and elevators, and short turns around the block. The appliance is made by a concern noted for quality steel products for more than a half century, and is fully guaranteed by the distributor.

A RAPID METHOD OF COPYING CHARTS

By DRURY HINTON, M.D., F.A.C.S., Philadelphia, Pa.

Recently it was necessary for me to copy a large number of T. P. R. (time, pulse, respiration) charts, which is usually a slow and tedious process. The work was much facilitated when the idea, described below, was put into practice.

The materials necessary for the method are:

a. Two self-inking stamp pads, one red and the other black.
b. Three pencils with erasers.
c. An office table with transparent glass top.
d. A portable electric light.
e. A heavy paper clip.
f. A trousers' hanger.

Preparation of materials:—The three pencil erasers are sandpapered down into truncated cones. In the end of one of them a small hole is bored with sandpaper wound

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GRAPHIC CLINICAL CHART. Designed by J. P. Crozer Griffith, M.D.

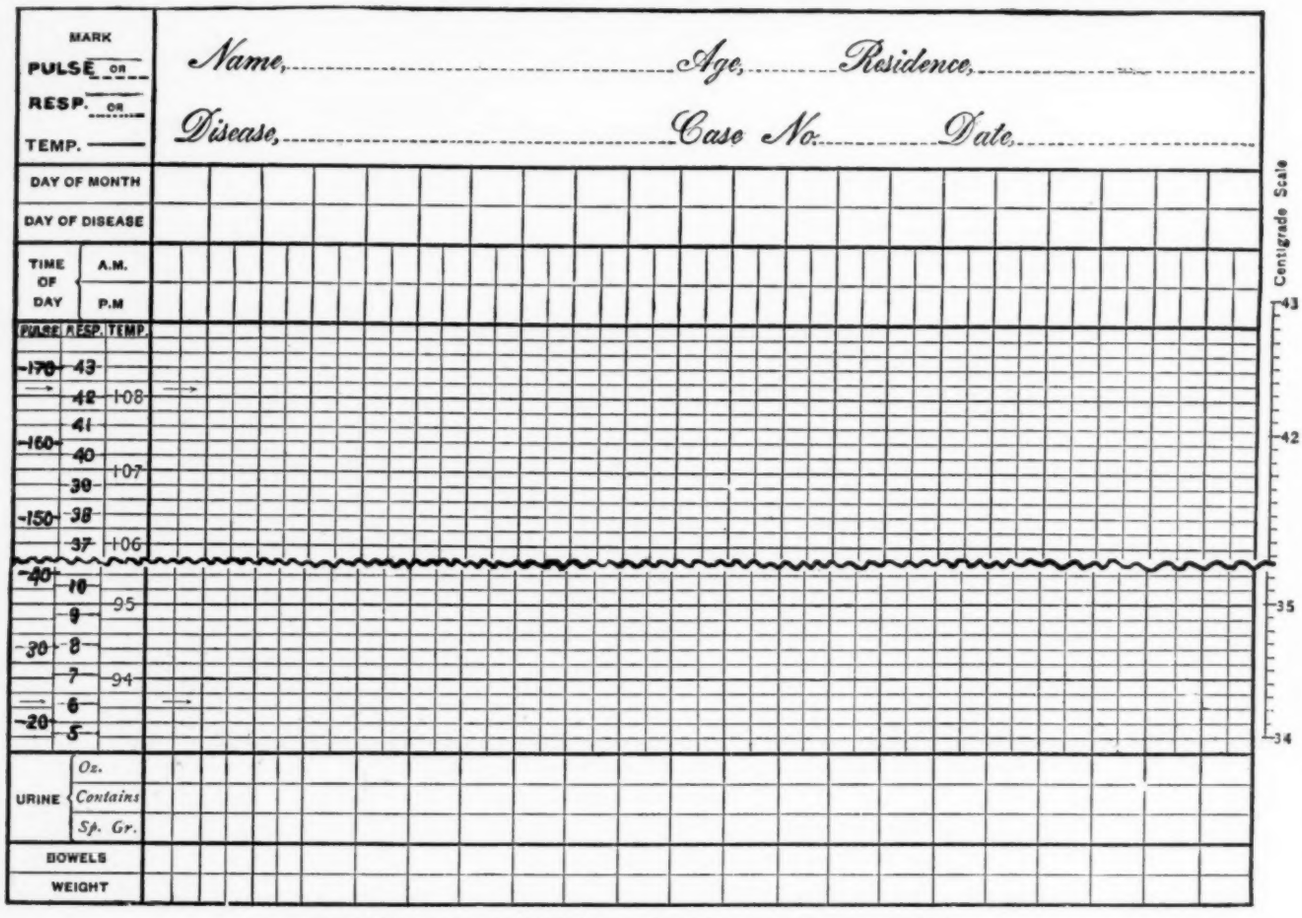

Figure 3

around a matchstick. This one is used with black ink to record respirations. One of the others with black ink is used to record temperature and the other with red

Figure 1

ink records the pulse rate. (See figure 1.)

The materials are then assembled, as seen in (figure 2). The blank graphic clinical chart (figure 3) is fastened

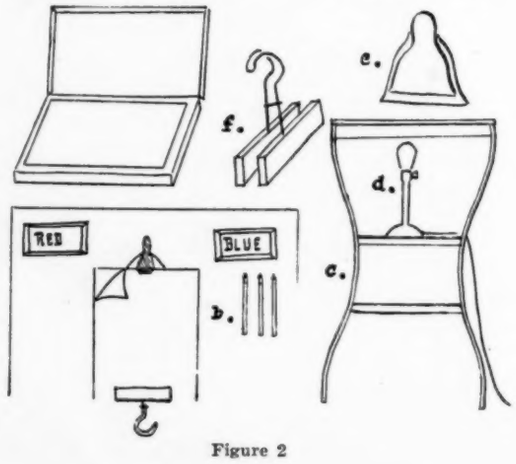

Figure 2

to the chart to be copied, which lies underneath it, by the paper clip. The lower ends of both charts are then attached to the glass slab by the trousers' hanger. With the light from the electric bulb shining through from below, it is a simple matter to copy the chart with great rapidity by stamping an impression exactly over the dots seen below.

This method is also applicable to the routine daily charting done on the wards, and has the advantages of uniformity, speed and economy. This has doubtless been done before in the same or modified fashion in some hospitals, but the repetition here may be of some service to those who have not heard of it.

NEW APPARATUS FOR ASPIRATING BODY FLUIDS

By DANIEL McLELLAN, M.D., C.M., B.A., Vancouver, B. C.

The following is a brief description of a new apparatus for aspirating body fluids.

A 30 c.c Luer syringe is connected by means of an adapter and rubber tube to the stem of a "y" shaped glass tube. A Luer needle is connected by means of an adapter and rubber tubing to the receiving arm of the tube. To the discharging arm of the tube is attached a longer section of rubber tubing, in the exit end of which is inserted an adapter of the same caliber as that in the receiving end.

At a convenient distance between the aspirating needle and the receiving arm of the tube a glass valve is inserted, and at a convenient distance between the dis-

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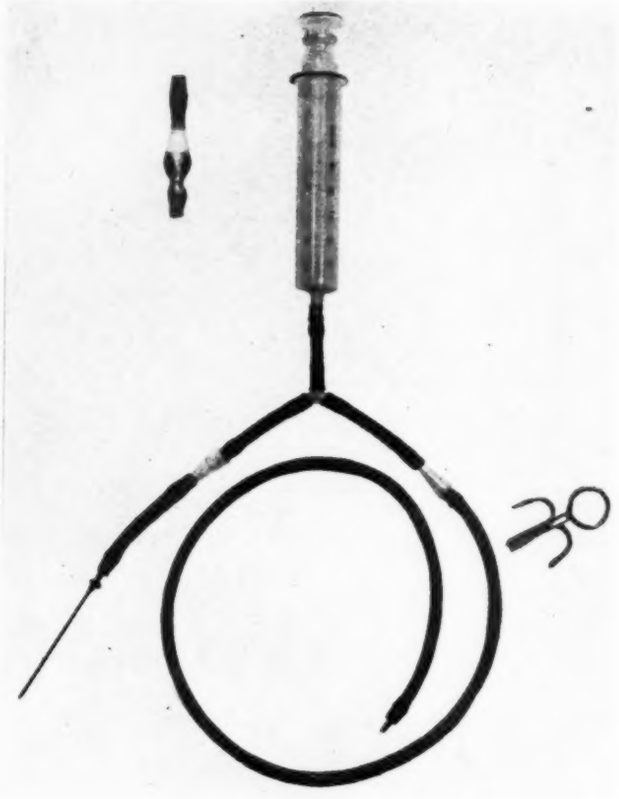


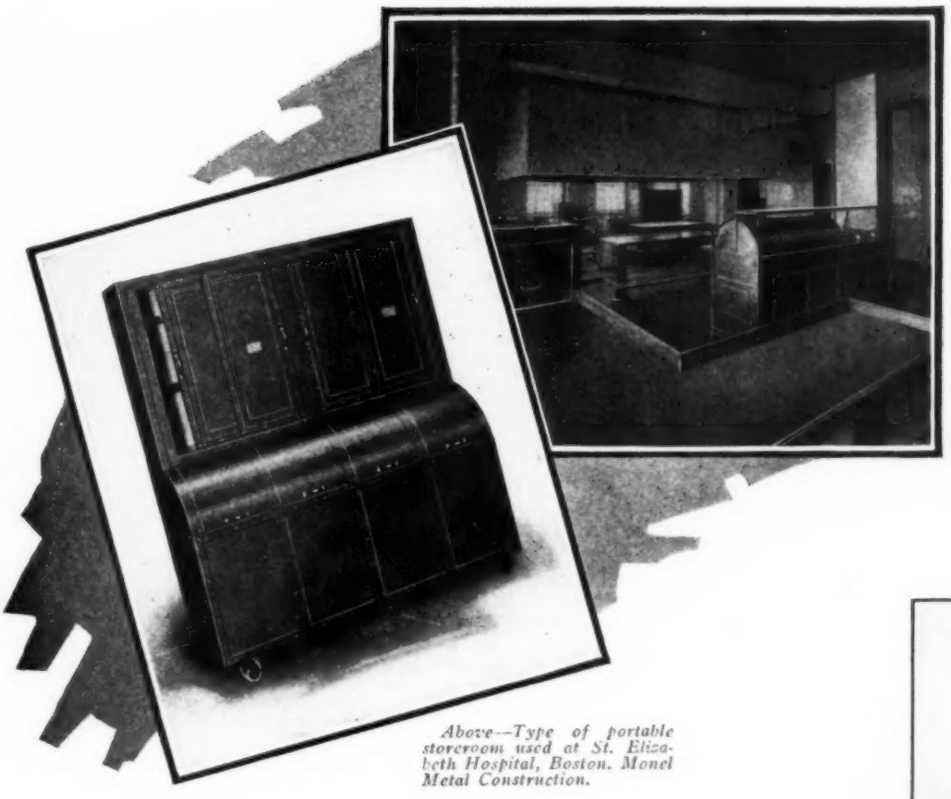
charging arm of the tube and the exit end of the long discharging rubber tube a similar glass valve is inserted.

The glass valve in the receiving arm is placed so that, as the piston of the syringe is drawn up the valve opens, allowing the fluid to be drawn up into the syringe, and as the piston is pushed down the valve closes, preventing the passage of fluid backward through the needle. The glass valve in the discharging arm is so placed that as the piston of the syringe is pushed down, the valve opens, allowing the passage of fluid through the valve and out at the exit end of the long rubber tube, and as the piston is drawn up the valve closes, preventing fluid from being drawn backwards through the discharging arm.

These valves, as shown in the illustration, are of ground glass accurately fitted and are cone-shaped. When properly placed in position, the apex of the cone in the receiving arm will point towards the aspirating needle, while in the dischargng arm the base of the cone will be towards the exit end of the long rubber tube.

It will be seen at a glance that with each up-stroke of the syringe, the valve in the receiving arm opens while the valve in the discharging arm closes, and with each downstroke the valve in the discharging arm opens while the valve in the receiving arm closes, the action being automatic.

Fill the apparatus with normal saline solution so as to expel the air. This is done by simply placing the aspirating needle in a bowl of saline or sterile water and taking a few strokes of the syringe. The last bubble may be expelled by inverting the syringe in exactly the same manner as before giving an ordinary hypodermic injection. A suitable clamp, such as in the illustration, is then placed on the long tube at the point at which it appears in the illustration. This is to prevent the running off of the fluid and thus emptying the apparatus. This clamp is left in place until the needle is inserted into the chest and is then removed. It is important that



Typical view of the All-Monel Metal Kitchen at the St. Elizabeth Hospital, Boston, installed by Mitchell Woodbury Co.

Above—Type of portable storeroom used at St. Elizabeth Hospital, Boston. Monel Metal Construction.

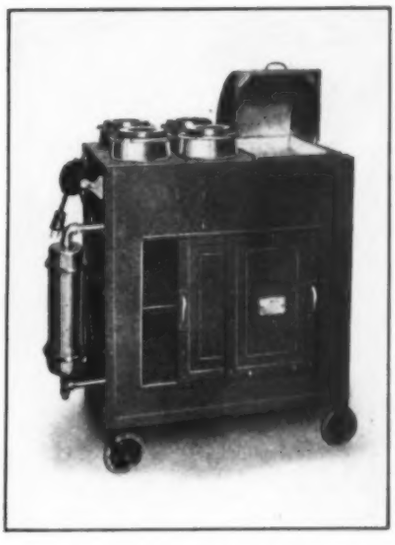
Modern Hospital Equipment

Our Installations Represent the Judgment of Expert Equipment Engineers

EQUIPMENT manufactured by Mitchell Woodbury Company is the type that is generally approved and accepted by Hospital Authorities.

Each piece of equipment fulfills its specific requirement and has been designed by our Engineers from a practical standpoint, for strenuous service under all conditions.

Hospital officials are cordially invited to confer with our Engineers in reference to equipping or re-equipping their kitchens.



Above—Type of Portable Electric Diet Table used at St. Elizabeth Hospital, Boston, Monel Metal construction. This table is accepted as the most modern diet room service truck employed where central kitchen service is in operation.

COMPLETE STOCKS OF

CHINA—GLASS—SILVER
KITCHEN APPARATUS

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When using advertisements see Classified Index, also refer to YEAR BOOK.

the exit end of the long rubber tube should not be left standing open. It should have an adapter of the same caliber as that in the receiving end. Otherwise, the "balance of resistance" is upset and the valves will not work so accurately.

When the needle is inserted into the chest, and everything ready, remove the clamp, and proceed by easy steady strokes to evacuate the fluid from the chest.

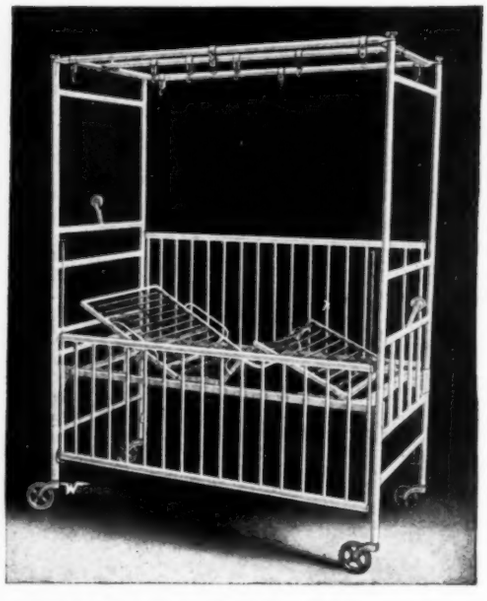
If you wish to prove beforehand that your needle is actually in the fluid connect your syringe direct with the needle, draw up a small quantity of fluid, thus proving the point; then connect up with the apparatus and proceed.

This apparatus is intended for fluid, not for pus; and although it has been used successfully in fairly thick fluid, the writer makes no apology in case it is found not applicable to cases of that kind. This apparatus was successfully demonstrated on a patient at the November, 1924, meeting of the Vancouver Medical Association and is in use in the Vancouver General Hospital and at the Rotary Clinic for Chest diseases, Vancouver, B. C. It is a modified part of a new apparatus for blood transfusion which the writer hopes to be able to have for use when the technique is sufficiently perfected.

CHILDREN'S FRACTURE BED

One of the most recent developments in children's hospital equipment is a new fracture bed. It serves many purposes, combining, as it does, both the Balkan fracture and Fowler frames. Before the advent of this equipment it was necessary to rely upon makeshift apparatus in order to apply the Balkan and Fowler principles in the hospital treatment of the child.

The Balkan frame is an all metal structure which provides for traction on the limbs as well as suspension. It is permanently attached to the crib, is sturdily built and is rigid. The suspension hooks are moveable and are adjustable along the entire length of the rods. Ball-



bearing pulleys at the head and foot provide for traction.

The back and knee sections may be elevated to any degree. The bed is built almost entirely of tubular steel, covered with heavily baked enamel. Either or both sides may be lowered to facilitate handling the child.

The whole equipment may be easily moved about upon the large rubber tired wheel casters. The size is sixty inches long and twenty-nine inches wide.

RESTORING THE SICK TO HEALTH

AND

KEEPING WELL PEOPLE WELL

This double function—*keeping well people well and restoring the sick to health*—is one of the reasons why the hospital idea has been so universally accepted by the American people.

Restoring the sick to health, while originally the only function of the hospital, is more and more being supplemented by the service of *keeping well people well,* and all over the country hospitals are taking active leadership in health educational work.

Quite properly the service of any hospital includes educational work with resident patients, out-patients, and through its community contacts—educational work to the end of preventing those abuses of right living which lead to ill balanced metabolism which so frequently shows itself through a diminished alkalinity of the blood and tissues due to an excess of acid products—*acidosis.* This excess acid is frequently observed for the first time when the patient enters the hospital or dispensary for diagnosis. It is the beneficient service of the hospital staff to go beneath the surface of things and find out the underlying causes.

Whatever may be the remote cause of hyperacidity, the simple corrective measures here discussed should be considered by those responsible for the diagnosis, treatment and care of patients in hospitals and similar institutions. Also a note of warning may well be sounded to those who are well so that they may conserve health.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE—The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

PHILLIPS' Milk of Magnesia

CAUTION. Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

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THE CHARLES H. PHILLIPS CHEMICAL CO., New York and London

BRINGING THE HOME ATMOSPHERE TO THE HOSPITAL BY MEANS OF COLOR

WHILE an established fact in theory, the responsive value of color to hospital patients is more and more recognized as a practical working principle, by hospital authorities throughout this country and Europe.

Hospital architects are directed by these authorities to specify colors in the various materials employed as well as in the decorations and furnishings.

While the application of materials to create the softness and suppleness of home surroundings, for sanitary

reasons, seems limited, nevertheless, these limited mediums should be used and applied to the fullest extent.

Floors in general, tiled floors, terrazzo floors and mastic composition floors should be tinted beyond the sombre grey of most of the ingredients employed, just enough to be as neutral as a floor. For waiting rooms, halls and wards more warmly colored borders are a successful aid in breaking the monotony of large expanses of floor.

Where glazed tiles are used for walls and dados in operating rooms, halls, bathrooms, backing walls of lavatories in wards and rooms, cheerful color bands or decorated tile borders should be introduced.

The decoration of walls and ceiling should be carefully considered as they are the largest surfaces of a room to convey the effect of color. Naturally only the lighter shades and tints are used for the painting and enamelling of walls and ceilings, with deeper tones and shades for wainscoting and dado effects, and with still stronger border bands and edging lines. The effective spectrum value of colors may thus be summed up: exciting—from scarlet to yellow; tranquilizing—yellow green to violet-blue; subduing—blue to purple.

Effects to be Gained Through Draperies

Simplicity and ease of cleaning are the essential points in hospital decoration. A remarkable departure from the former austerity of hospital interiors can be safely risked at present and in the future, by introducing draperies and effective furniture coverings, especially for the waiting rooms, lounges, libraries and private rooms. Even the large wards may be made more cheerful by mellow broken light through an enchanting drapery material.

There are being manufactured now on various looms throughout the country materials for draperies and furniture coverings of all sorts of textures, weights, colors and design, from the flimsiest gauze to heavy velvets and

St. Elizabeth's Hospital
Lafayette, Ind.
Main Bldg.
Architect:
D. X. Murphy & Bro.
Plumber:
Wallace Bros. Co.

City Contagious Hospital
Madison, Wisconsin
Architect:
Claude & Starck
Plumber:
W. J. Hyland, Inc.

Allen Memorial Hospital
Waterloo, Iowa
Architect:
Mortimer B. Cleveland
Plumber:
Quest & Smith

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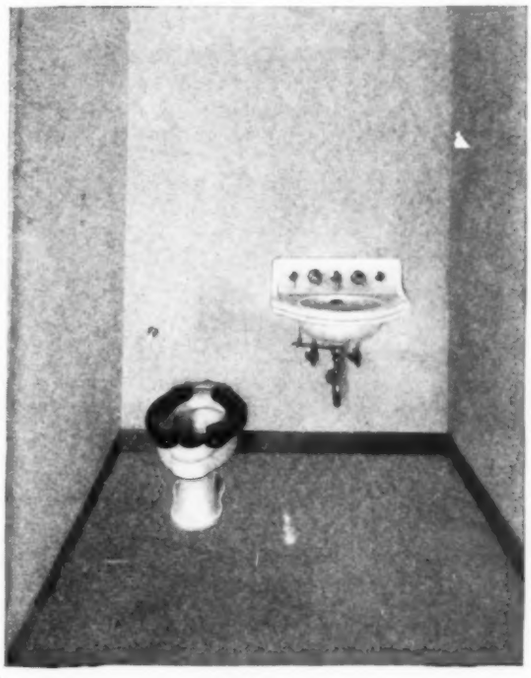


Men's Toilet
St. Lawrence Hospital, Lansing, Michigan

Oregon State Hospital
Salem, Oregon
Architect:
Lazarus, Whitehouse & Fouilhoux
Plumber:
J. A. Bernardi

Washington County Memorial Hospital
Bartlesville, Oklahoma
Architect:
Walton Everman
Plumber:
Sell & Orr Heating Company

Addition to St. Joseph's Hospital
South Bend, Indiana
Architect:
Fryermuth & Maurer
Plumber:
J. E. Haney

Hospitals Require Out-of-the-ordinary Plumbing

Hospital plumbing is exceptional, in that every hospital apparently has different requirements to be met and different problems to be overcome.

Clow has pioneered the design, construction and stocking of the out-of-the-ordinary fixtures and fittings that meet such requirements and solve such problems. For example, a goodly percentage of the therapeutic equipment in use today is Clow designed and Clow built. When Clow is specified for all plumbing there is an assurance of completeness and thoroughness for Clow is in a position to furnish everything that the installation requires—in plumbing fixtures and therapeutic equipment.

Such modern hospitals as those pictured herewith have learned the value of Clow of all plumbing.

JAMES B. CLOW & SONS, 534-546 S. FRANKLIN ST., CHICAGO
Sales Offices in Principal Cities

CLOW

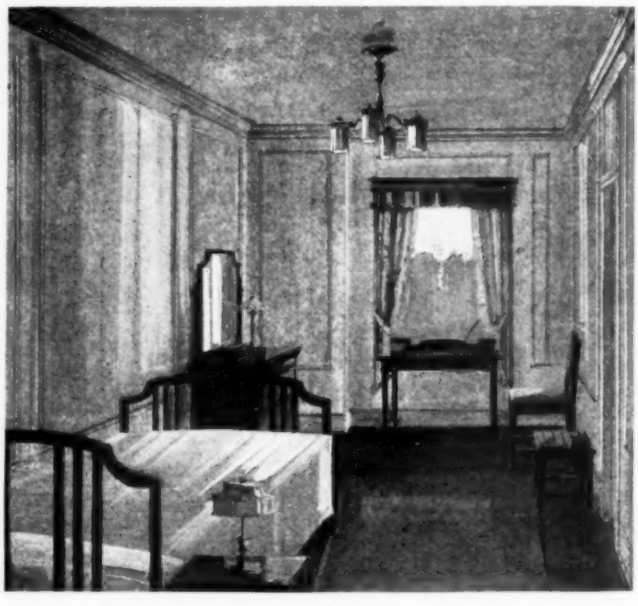
mohairs, that are absolutely sun and tub fast, and will withstand all the washing and ironing as will bed linens.

And right there, at the windows can the color charm of the home be introduced by having the windows neatly draped consistent with the operation of the sash, either for the double hung window, the casement sash or the fenestra steel window of the wards. What happy spots of gayety and life can be introduced by a neatly draped window with interesting materials.

There is also made now, a class of furniture, equally as soft and alluring as overstuffed pieces, that has a complete finished frame with detachable cushion effect, seats, backs and arms, whose covers are like slip covers, easily removed for the laundry and mangle, slipped back on the cushion and the cushion back on the piece of furniture in their respective places.

The same demands and requirements apply to rugs. A number of different textiles are being made now, to add beauty and utility and yet withstand what sanitary treatments may be required in cleaning them. These textiles will stand for any kind of scrubbing, hose-wash or any kind of disinfecting process which may be required. The same arguments apply to the use of more gaily colored bedspreads, blankets and pillow shams.

The idea is not to overdo things in color, but to get away from the established theory of white, white and



white. While it may be cleanliness idealized, it will immediately impress the patient that he or she is in a hospital; and a sick trend of thought is the outcome. The use of cheerful colors in wall decoration, and in furnishings tend to restore a home-like atmosphere and to alleviate the drabness too often associated with the hospital.

ELECTRIC STEAM RADIATORS

The methods of heating institutions are undergoing long desired improvements. With the rapid growth of great electric generating stations and the constantly lowering costs of electricity it is now possible in many sections to enjoy electric steam heat at very reasonable cost. It has long been felt that electricity would be ideal for general heating as well as for small, special heating appliances, and the development of this idea is being carried forward.

The electric steam radiator is an accomplished fact and can be obtained in a number of sizes for permanent installation on the floor or wall, or portable, to be moved

from one place to another.

These units consist of a cast iron radiator fitted with extra size nipples at the bottom, into which the heating element is fitted. This element extends through the entire radiator, assuring even heat in every column. A three heat switch is made a part of each radiator. The heating element is enclosed in a seamless brass tube which protects it and provides a large radiating surface for heating the water which surrounds it.

When the electric connection has been made the radiator is supplied with water through a filler cup in sufficient quantity to cover the heating element. One filling will last several months. Current is applied by turning the switch to "high," for bringing the water to the steaming point, after which it can be turned to "medium" or "low"

to maintain heat with a reduced amount of current.

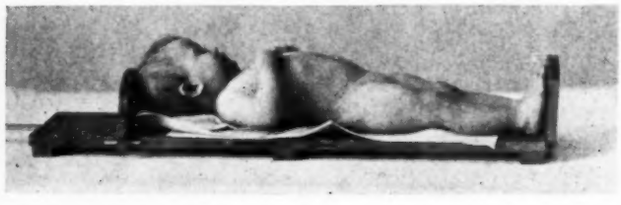
These radiators are also supplied with a thermostat having a range from fifty to eighty degrees. This gives an automatic control, insuring economy and uniform room temperature. In the matter of cost, the practicability of electrical heating has been greatly assisted in the last two years by reduction of rates for current and the increasing cost of fuels.

A NEW MEASURING BOARD FOR BABIES

The U. S. Bureau of Standards has cooperated with the children's bureau of the U. S. Department of Labor in designing and building a new and improved board for measuring babies. A patent has been applied for by the Bureau of Standards and will be dedicated to the public in accordance with government policy.

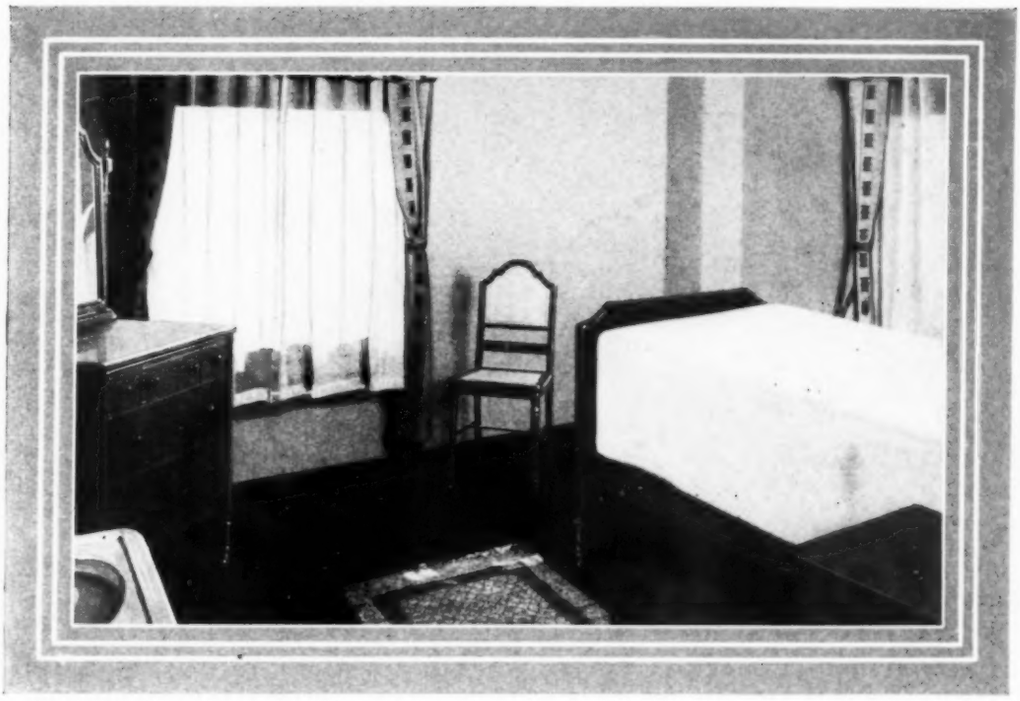
The board consists of a flat base upon which the baby is placed, lying down, with movable wooden "slides" at right angles to the base, one at the foot and one at the head. The measuring scale is in a hollowed groove in the base.

There are two striking differences between this new board and those most commonly used. First, it has two movable slides instead of one, and second, readings may



be taken from the outside, instead of from the inside of the slide which rests against the baby's head.

The advantage of having two movable slides is that the baby may be placed on the board, quickly, comfortably,



Other hospitals using Simmons Furniture

Columbia Hospital
Milwaukee, Wisconsin
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Oak Park, Illinois
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Port Jervis, New York
Private Hospital
Houston, Texas
Virginia Baptist Hospital
Lynchburg, Virginia
Ingham County Tuberculosis Sanitorium
Lansing, Michigan
Guthrie Hospital
Huntington, West Virginia
Wellington Hospital
Wellington, Texas
Hunts Point Hospital
Bronx, New York
Norwegian Lutheran Hospital
Chicago, Illinois
Beaver County Tuberculosis Hospital
Monaco, Pennsylvania
Overall Memorial Hospital
Coleman, Texas
Paris W & B Clinic
Paris, Arkansas
Harrisburg Hospital
Harrisburg, Illinois
Veterans' Bldg. Insane Hospital
Meridian, Mississippi
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Springfield, Missouri
Peoria State Hospital
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In case of Fire, It will not Burn!

Absolute safety for patients is a basic law with hospital authorities. To a fireproof building, Simmons Steel Bedroom Furniture adds final and definite assurance of security.

Not a splinter of wood is used in its construction. Built entirely of steel, it resists changes of climate, dampness and dryness, without weakening or warping. Frequent shifting from room to room does not send it to the repair shop. Mirror standards will not work loose or caster spindles split the legs. Its permanent finishes are unharmed by alcohol, antiseptics, mild disinfectants or boiling water.

See this economical, durable furniture in a wide range of beautiful designs and color finishes at your favorite furniture store, or write to us.

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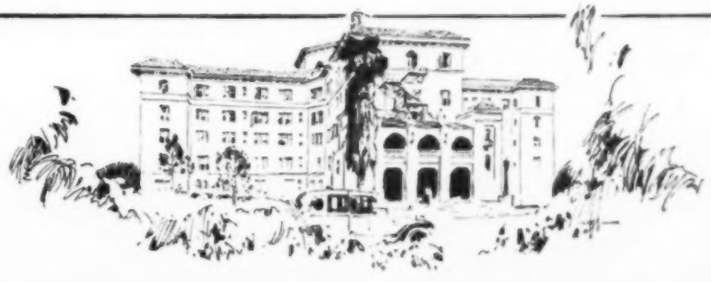
Steel Bedroom Furniture
FOR HOSPITALS AND INSTITUTIONS

Hollywood Hospital, Hollywood, California. Equipped with Simmons Steel Furniture, Suite 110. Simmons Bed is design 1829.



and with a minimum of handling. Both slides are adjusted to his height (or length) at whatever point between the two he may be placed.

It is also a distinct advantage to be able to make outside readings. On the usual measuring scale the baby's position on the board frequently interferes with a clear view of the scale and makes readings from the inside of the slide difficult. No such difficulty exists to interfere with accurate and speedy readings on the new board.

The measuring scale on the new board is furnished by a meter stick to one end of which the foot slide is attached. This meter stick fits into the slot or groove running down the center of the board and may be moved back and forth as required by the position of the babies being measured. (The children's bureau employs the centimeter scale for measurements used as the basis for scientific reports and the inch scale in its popular demonstrations.) The measurement is shown by a brass indicator screwed to the outside of the head-slide with a pointer projecting over the edge of the slot in which the meter stick moves. An accurate reading can be made from the outside of the slide to which the indicator is attached because the distance from the baby's head (which touches the inside of the slide) to the pointer is equal to and compensates for the distance from the foot slide to zero point on the meter stick.

ARTIFICIAL LIGHT IN THERAPEUTICS*

SUNLIGHT from time immemorial and artificial light in recent years have been used as adjuncts to other agencies in the treatment of disease. That light has valuable therapeutic properties has been demonstrated and acknowledged so as to be beyond any question. Unfortunately many who undertake to apply it appear to be ignorant either of the physiological reaction or of the characteristics of different kinds of light.

Light treatments should, of course, be prescribed by competent authority. It is not intended to discuss treatment, but rather it is hoped to point out a few of the characteristics of the light of the Mazda lamp which will give a better understanding of its nature and tend to avoid some misconceptions and claims which are at variance with the facts.

Light—A Form of Radiant Energy

Light is a form of radiant energy which differs from electricity and heat in the length of wave or rate of vibration. Visible light composes a range of such wave lengths from red at .7/u* through orange, yellow, green and blue to violet at .4/u.

The range of radiation wave length extends beyond those which we can see. Wave lengths of invisible radiation longer than those of red light are generally called heat or infra-red rays, because they are most commonly so apprehended. For example, we can feel the heat of a black hot object at considerable distance.

Wave lengths shorter than those of violet light are recorded by the photographic plate and in other chemical reactions and so are called chemical or ultra-violet rays.

In general, we are more conscious of the heating effects of the longer waves and the chemical effects of the shorter waves, but there is no critical change in these effects at the limits of the visible spectrum or range. In other words, there are still some heat and chemical effects of radiation in the so-called visible range (.4/u to .7/u).

Some light sources produce radiation made up of just a few separated wave lengths producing what are known as line or band spectra. Sunlight and the light of the incan-

*Published by courtesy of the Edison Lamp Works of the General Electric Co., Harrison, N. J.

descent lamp include a practically continuous range of wave lengths from the heat rays or infra-red through the visible spectrum and the chemical rays or ultra-violet.

Since the temperature of the incandescent filament is far lower than that of the sun, incandescent light contains a larger proportion of heat radiation and a smaller proportion of chemical radiation than sunlight. Likewise it appears yellowish when contrasted with the latter. The proportional distribution of energy from a typical high efficiency, gas filled, tungsten filament Mazda C lamp, is approximately as shown in figure 1. Here the amount of energy at the point of maximum visibility (.56/u) is taken as unity and other values are relative rather than absolute. The section shown by cross hatching represents the wave lengths which are visible. The portion under

(*/u is the scientific unit of wave length of radiation and is equal to .001 millimeter or .00004 inches.)

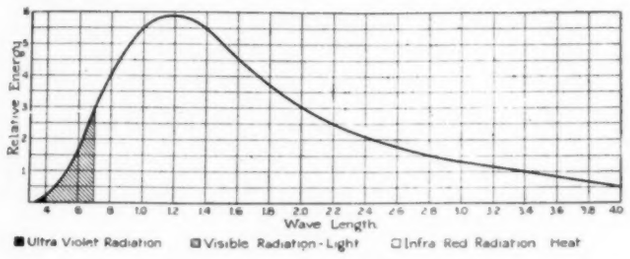


Figure 1.—The proportional distribution of energy from a typical large size Mazda C lamp.

the curve at the right is heat radiation. It is evident that while relatively speaking our modern illuminants are quite efficient yet the net or over all efficiency for lighting is quite low and leaves remarkable opportunities for future development.

The term cold light is frequently heard as representing an ideal toward which we strive. In simple language this implies an illuminant which radiates the major portion of its energy in the visible range.

Incandescent Lamps for Therapeutic Work

Incandescent lamps of various types are legitimately used for therapeutic work. They are very effective from the standpoint of infra-red or heat radiation but the claim should not be made that they are especially useful

Figure 2.—(1) Sketch of an adjustable stand and reflector for large size Mazda C lamps used in therapy; (2) A parabolic reflector with special mounting employing small incandescent lamps for local heating effects: (3) A portable light cabinet for local heating.

from the standpoint of ultra-violet radiation. In the first place, the filament does not emit a great amount of the short waves and, further, ordinary clear glass such as is used for the bulb has the property of absorbing most of the ultra-violet radiation, merely transmitting a little at the upper part of the range. Referring to the curve in 1, it will be seen that it strikes zero at approximately .32/u and there is obviously little energy emitted. Where actinic or ultra-violet action is desired some illuminant other than the incandescent lamp should be employed. The open arc lamp without a glass globe or screen, or the mercury vapor lamp in a quartz bulb

FOUR THINGS

which every physician should know about evaporated milk, and which—begging pardon!—a good many do *not* know

1 Evaporated milk—Carnation is evaporated milk—is a *specific kind* of milk. It is not "sweetened condensed" milk; it contains no sugar except natural milk sugar. It is not powdered milk. It *is* milk concentrated in liquid form by partial evaporation of the water content. Dilution with approximately an equal amount of water restores it to whole milk of above normal richness and consistency.

2 Evaporated milk from such great institutions as the Carnation Milk Products Company is milk of exceptional quality from selected herds. It is surrounded by every hygienic safeguard and processed under scientific regulation. Sterilization in hermetically sealed cans insures absolute safety. Furthermore, this milk is *rich* milk. In Carnation, the butterfat content is never below 7.8 per cent, equivalent to 3.9 milk after dilution.

3 Carnation Milk has received the endorsement of high medical authority as a pure, nourishing, digestible milk, of constant quality and universal availability. It is frequently prescribed by leading pediatrists for routine feeding, for use in certain selected cases, and for dependence whenever the quality of the ordinary milk supply is in doubt.

4 Many hospitals employ Carnation Milk for cooking, baking, making ice cream, and other routine uses. In addition, Carnation Milk performs the all-important function of insuring against every emergency the hospital's supply of pure milk.

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Carnation Milk

"From Contented Cows"

are both rich in ultra-violet light.

Ultra-violet light should be used with extreme caution as under certain conditions very harmful effects result which are not apparent until some time after exposure. The thermic or radiant heat action is excellent with the incandescent lamp.

Radiant Heat Has Greater Penetration

Radiant heat has a much greater penetrating power than conducted heat such as furnished by the hot water bag or similar devices. A general application of radiant heat to the entire body by means of a suitable cabinet has been found quite effective for certain afflictions of a rather wide nature. In other instances local applications of radiant heat are effective.

A light cabinet should contain a number of relatively small lamps (40 to 60 watts), equally distributed throughout. A white enameled surface on the interior is as effective as mirrored lining in reflecting and diffusing the heat and light. Lamps should be arranged on several circuits with conveniently placed switches to enable one to control the degree of heat.

A similar device consisting of what might be considered a section of a larger cabinet, portable in nature, as shown in figure 2 (3), proves useful to place over an arm or leg to "bake" the afflicted member.

For the application of local radiant treatment a small parabolic reflector, figure 2 (2), with a concentrated filament lamp from 100 to 250 watts is used in the same manner as a heating pad and is much quicker in action. A parabolic reflector redirects the invisible heat rays in a comparatively narrow beam just as the automobile headlight reflects the visible rays.

Larger Reflectors Used for Higher Power

Where higher power is required similar larger reflectors mounted on an adjustable stand figure 2 (1), used with the 750, 1,000 and 1,500 watt Mazda C lamps. With these larger lamps a special deep blue glass bulb is often used. Contrary to the general impression the blue glass adds nothing whatever to the radiation produced by the lamp, but merely absorbs a portion (about 60 per cent) of the visible light allowing the ultra-violet and infra-red radiation to remain practically unchanged. Other blue glasses may have radically different characteristics. The action of the particular blue bulb used in therapeutic application is, therefore, quite identical with that of the clear bulb lamp save that it reduces the amount of light in the room and makes visual conditions much more comfortable for the patient.

HOW TO DRY AND CLEAN HYPODERMIC NEEDLES

By WALTER M. BRUNET, M.D., Brooklyn, N. Y.

The care of hypodermic needles is, at best, a disagreeable task and oftentimes after a hypodermic or other injection, the needle is laid aside to be cleaned and dried later. Usually when the job of cleaning the needle is reached the needle is found to be clogged up. Oxidation is the foe of all steel needles and this destructive power is due to the fact that needles are put away without being properly dried.

The simple inexpensive instrument, shown here, is for the purpose of drying and cleaning hypodermic needles.

It consists of an aseptic rubber bulb, one-half ounce capacity, into the neck of which is inserted a male Luer adapter. This adapter fits all Luer needles.

To use this instrument, the adapter is inserted into

the hub of the needle and the bulb compressed several times. In this manner, the in and out action of the air through the needle will blow out the moisture and dry it thoroughly.

STRIPS FOR IDENTIFYING BABIES

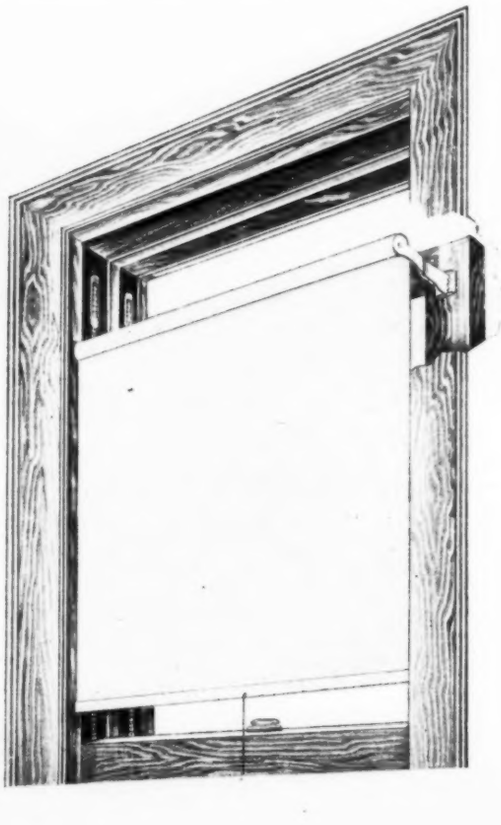
Baby identification strips, such as the one shown here, have been designed for the identification of new-born babies in the hospital. These consist of a strip of plaster,

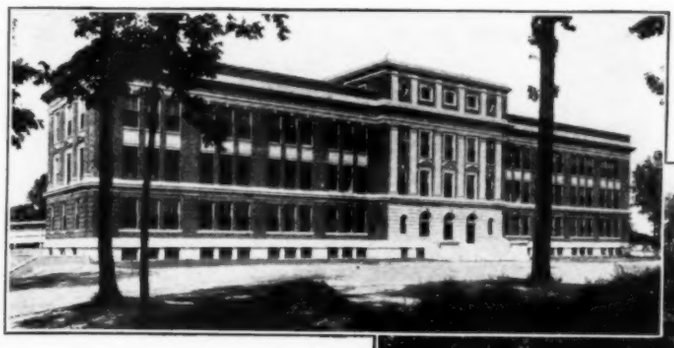
covered with soft lint. The strip is placed around the babies' wrist or ankle and is held in position by the plaster adhering to itself, but which does not touch the baby's skin. The name of the baby is written on the back of the band.

SHADE CONTROL FOR WINDOW VENTILATION

A new device that provides shade control for window ventilation has been especially designed for hospital use. This detachable ventilating shade has two styles of brackets. The long style brackets hang the shade so that the roll of the shade is turned in, as shown in the picture, while the short style brackets hang the shade so that the roll is turned out.

The detachable shade brackets are fastened upon the

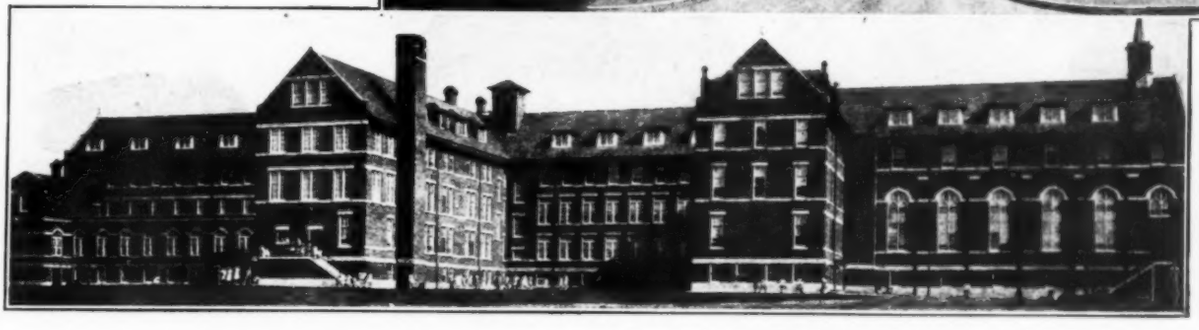




Army Medical School, Walter Reed Hospital, Washington, D. C.
completely Whale-Bone-Ite equipped
(STYLE NO. 23-9)

Right, Boston Lying-In Hospital Boston, Mass.
completely Whale-Bone-Ite equipped
(STYLE NO. 18½-59, EBONY)

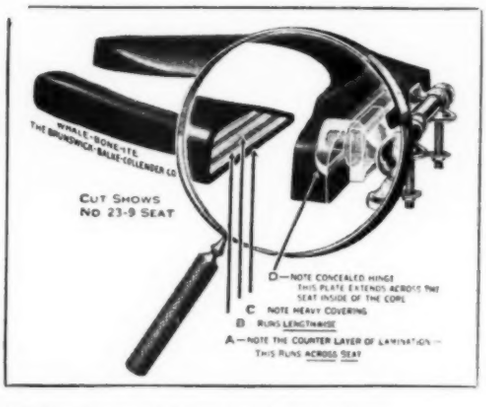
Below, The new St. Joseph's Home for Children, Erie, Pennsylvania
completely Whale-Bone-Ite equipped
(STYLE NO. 23-9, EBONY)



The experience of hundreds of hospitals with

Whale-Bone-Ite Toilet Seats

Long, satisfactory service — no repairs or upkeep expense — sanitary and non-inflammable



THE testimony of hundreds of leading hospitals where Whale-Bone-Ite sanitary equipment is installed is the most convincing proof of its supremacy. Today new hospitals are installing it everywhere, and old hospitals are making it their *final replacement.*

Read these 10 important exclusive features:

Permanent Durability	Sanitary
Easiest Cleaned	Comfortable
Acid-Proof	Non-Inflammable
Permanent Finish	Non-Warping
No Exposed Metal	One-Piece Construction

Whale-Bone-Ite seats are non-inflammable, hence they reduce your fire risk, a most important consideration.

"The Seat of No Apologies"
Note the hinge construction

The ebony black, or rich mahogany finish of Whale-Bone-Ite seats affords a most pleasing contrast with the tile and trim of the bathroom or lavatory.

Your jobber's salesman can give you full information, or write direct

WHALE-BONE-ITE DIVISION
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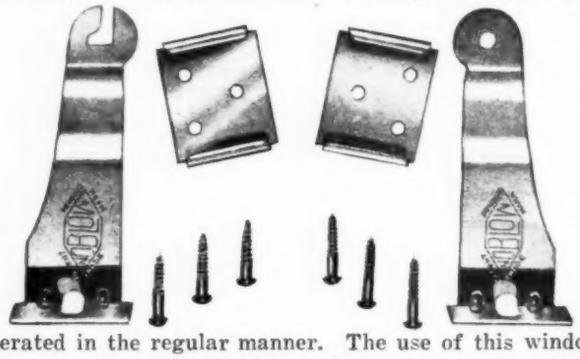
SEAT

top window, thereby permitting the shade to be hung upon the upper window. By this arrangement the window and shade can be lowered at one time, the shade being



operated in the regular manner. The use of this window shade prevents the blowing and flapping of the shade.

PORTABLE HIGH-FREQUENCY APPARATUS

This portable high frequency machine has been designed for use throughout the hospital. It has available a strength of current which covers practically all applications of high-frequency currents and can be used on the various kinds of ordinating current available in hospitals

and in offices. It also contains an additional control which makes possible the use of the machine for delicate treatments. Safety of operation is insured through a triple protection between the source of the current and the point of application.

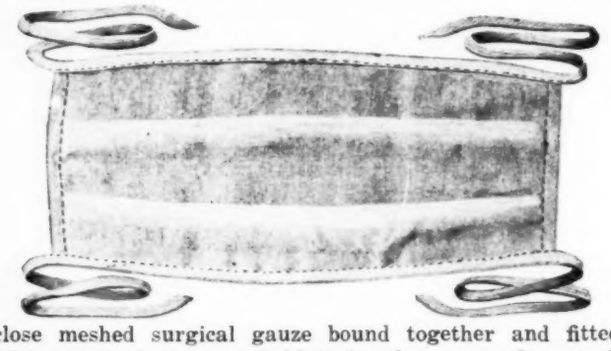
To get at the distinguishing marks of a professional worker it is the part of wisdom to look first at the historic "learned professions" of medicine, law, and divinity. All three involve: (1) a considerable period of special preparation and training, tending to become more exacting; (2) a public and frequently legal recognition of professional status, by examination, registration, ordination, and the like; (3) eligibility to membership in professional societies and associations carrying with it the obligation to maintain professional standards of skill and conduct; (4) a consequent position of responsibility in and to the community; (5) practice of the profession as a permanent calling providing an adequate livelihood."—*Adams.*

OPERATING ROOM SANITARY HEADRESS

The knitted cotton cap of elastic qualities has been designed for surgeons and nurses to wear as a protective covering over the hair while in the operating room. When drawn on the head, it clings tightly. It can be washed, sterilized and used repeatedly.

NOSE AND MOUTH MASKS

A handy mask for surgeons and nurses, shown here, has been devised for the protection of patients during operations. The mask is made of several layers of a



close meshed surgical gauze bound together and fitted with attached tapes to hold it in place over the mouth and nose. The mask can be washed and sterilized.

HOW TO SECURE CLEAN STEAM

Clean steam for turbine and engine operation is essential in these days of high steam speed, high temperatures, and high pressures.

It is not uncommon to find deposits of scale or dirt in engine cylinders and on turbine blades. Sodium sulphate, dirt, and calcium carbonate are the principal offenders. Not only do the impurities clog but they cause damage by cutting turbine blades and valve discs, making traps and valves inoperable and ruining engine cylinders.

A simple method to avoid these troubles is the installation of a steam purifier, the function of which is the elimination of moisture. By getting rid of the moisture all dirt is eliminated also, because it is only the water in steam that carries over the impurities. Dry steam cannot carry scaling impurities.

Although purifiers are installed principally to make steam clean, there is also a thermal saving involved. This saving is sometimes small and sometimes it amounts to a great deal. By removing all moisture, superheat can be increased. Hence from a heat standpoint, when using superheated steam, one can count on an increase of about seventeen degrees to every 1 per cent of moisture removed.

Also turbine manufacturers give the reduction in steam turbine water rate as 1 per cent for every twelve degrees increase in superheat. If 2 per cent of moisture is removed the superheat would therefore increase thirty-four degrees, which would be equivalent to almost 3 per cent reduction in turbine water rate. One can easily figure what this amounts to during an entire year. If may mean that the purifier will pay for itself within the first year as an economizing device, and in addition the owner gets clean steam and machine protection.

No. 6

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